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1985

Immediate Action
INTERIM CHANGE

Headquarters
Department of the Army
Washington, D. C.
23 May 1984

S/S 8 July with Chg/Encl.

AR 608-1
Interim Change
Number I03
Expires 23 May 1986

Personal Affairs

Army Community Service Program

Justification. This interim change includes policy changes in developing educational and health-related capability data banks for exceptional family members. It also includes a change in reporting agency services to HQDA (DAPC-EPA-S). This change in reported data has been assigned Requirements Control Symbol AG 884. These changes have been made to prevent adverse judicial rulings against the Army.

Expiration. This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

1. AR 608-1, 15 May 1983, is changed as follows:

Page 8-1. Paragraphs 8-1 and 8-3 are superseded as follows:

Paragraph 8-1.

Service members eligible to relocate their families at Government expense should identify family members with physical, emotional, or intellectual disorder to assignment authorities. This information will be considered when assignment decisions are being made.

Paragraph 8-3.

a. All ACS centers will maintain a listing of military and civilian special education and health-related services. All 50 States' health-related data will be collected through in-person interviews by ACS center representatives in coordination with regional Army Medical Centers on DA Form 4723-2-R (Health-Related Survey--Individual Facility Report). Definitions in DA Form 4723-2-R must be used in conducting the survey of health-related facilities (excludes schools with a medical component) located within a 40-mile radius of the installation. Civilian special education data for immediate school district jurisdictions in all 50 States will be collected from existing information data bases since Office of Management and Budget approval was denied for surveying school facilities. OCONUS (excluding Alaska and Hawaii) special education and health-related data will be collected by the Department of Defense Dependents' Schools (DODDS) and the Office of The Surgeon General (OTSG).

b. Each ACS center in every State will furnish a report of special education and health-related services to their MACOM ACS Office on DA Form 4723-R (Report of Special Education Services for the Exceptional Family Member) and DA Form 4723-1-R (Report of Health-Related Services for the Exceptional Family Member). The data collected on DA Form 4723-2-R will be used to complete DA Form 4723-1-R.

c. Upon receipt of DA Forms 4723-R and 4723-1-R, each MACOM ACS Office will complete an optical mark reader (OMR) booklet for each installation and forward to HQDA (DAPC-EPA-S), ALEX VA 22331, initially on 31 August 1984 and not later than 1 June of each year thereafter. DODDS and OTSG will simultaneously submit reports to HQDA (DAPC-EPA-S), ALEX VA 22331.

d. DA Form 4723-R, 4723-1-R, and 4723-2-R will be reproduced locally on 8½ x 11-inch paper. Copies for reproduction purposes are located at the back of this change.

e. In response to specific requests for assistance, installation ACS centers will provide direct casework services for personnel assignment authorities by researching the availability of programs and facilities in their regional areas and by reporting on the availability of actual openings in those programs.

2. Post these changes per DA Pam 310-13.

3. File this interim change in front of the publication.

(DAAG-PSC)

By Order of the Secretary of the Army:

JOHN A. WICKHAM, JR.
General, United States Army
Chief of Staff

Official:

ROBERT M. JOYCE
Major General, United States Army
The Adjutant General

Distribution:

To be distributed in accordance with DA Form 12-9A requirements for AR, Personal Affairs-D. Active Army, ARNG, USAR

REPORT OF SPECIAL EDUCATION SERVICES FOR THE EXCEPTIONAL FAMILY MEMBER

For use of this form, see AR 608-1; the proponent agency is TAGO.

DATE OF REPORT	*REQUIREMENT CONTROL SYMBOL AG-884(R1)*

TO: *(Name of Major Command, State and ZIP Code)*	**FROM:** *(Name of Installation, State and ZIP Code)*

NOTE: Indicate with a checkmark all those handicapping categories and conditions and grade levels for which a placement of a handicapped student is available.

HANDICAPPING CATEGORY/CONDITION	GRADE LEVEL APPROPRIATE TO CHRONOLOGICAL AGE CAPABILITY																																
	RESIDENTIAL INSTITUTION															SPECIAL DAY SCHOOL															EARLY CHILDHOOD PRESCHOOL				
	Preschool	Kindergt.	1st	2d	3d	4th	5th	6th	7th	8th	9th	10th	11th	12th	Other	Preschool	Kindergt.	1st	2d	3d	4th	5th	6th	7th	8th	9th	10th	11th	12th	Other	Preschool	Kindergt.	1st	2d	3d
PHYSICAL IMPAIRMENT																																		
Deaf																																		
Deaf-blind																																		
Hard of hearing																																		
Autistic																																		
Orthopedically impaired																																		
Visually handicapped, blind																																		
Visually handicapped, partially																																		
Other health impaired																																		
SPEECH/LANGUAGE IMPAIRMENT																																		
LEARNING IMPAIRMENT																																		
Moderate/severe mental retardation																																		
Specific learning disabilities																																		
SERIOUSLY EMOTIONALLY DISTURBED																																		

TYPED NAME OF INDIVIDUAL PREPARING REPORT	SIGNATURE	COMMERCIAL TEL. NO.	AUTOVON NO.

DEFINITIONS OF SPECIAL EDUCATION PLACEMENT TYPES
AND
HANDICAPPING CATEGORIES AND CONDITIONS
DA FORM 4723-R

- TYPE OF SPECIAL EDUCATION PLACEMENT

a. *Special Day School* — A state or private school that is a separate facility for children with a homogeneous need such as deaf, blind, deaf-blind, serious emotionally disturbed, other health impaired, autistic or multiple handicapped.

b. *Residential Institution* — A facility that provides 24 hour care *(usually with a medical support component)* to exceptional family members.

c. *Early Childhood Preschool* — A facility providing special education and related services for infants and youngsters.

- SPECIAL EDUCATION HANDICAPPING CATEGORY AND CONDITION

a. *Physical Impairment* — This group includes individuals exhibiting one or more of the following handicapping conditions: deaf, deaf-blind, hard of hearing, autistic, orthopedically impaired, blind, visually handicapped, other health impaired.

(1) *Deaf* — A hearing loss or deficit so severe that the person is impaired in processing linguistic information through hearing, with or without amplification, to the extent that his or her educational performance is adversely affected.

(2) *Deaf-Blind* — Concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that they cannot be accommodated in special education programs solely for the deaf or the blind.

(3) *Hard of Hearing* — A hearing impairment, whether permanent or fluctuating, that adversely affects a person's educational performance, but that does not constitute deafness.

(4) *Autistic* — A severe form of mental disorder that exhibits a majority of the following characteristics: (1) Lack of appropriate speech *(individuals are nonverbal or echolalic, i.e., parroting phrases spoken to them, but are unable to use them meaningfully in other contexts)*; (2) Lack of appropriate social behavior *(individuals appear to be oblivious to other people's presence or relate to people in a bizarre manner)*; (3) Apparent sensory deficit *(individuals are often incorrectly suspected of being blind or deaf)*; (4) Lack of appropriate play *(young individuals usually ignore toys or interact inappropriately with them)*; (5) Inappropriate and out of context emotional behavior *(individuals may display extreme tantrums, hysterical laughter, or, on the other hand, a virtual absence of emotional response)*; (6) High rates of stereotyped, repetitive behavior, referred to as self-stimulation *(e.g., flapping fingers or rhythmically rocking for hours without pause)*; and (7) Isolated areas of high-level functioning *("splinter skills", especially in the areas of music, number configurations, and manipulation of mechanical instruments).*

(5) *Orthpedically Impaired* — A severe orthopedic impairment that adversely affects a person's educational performance. The term includes congenital impairments *(such as clubfoot and absence of some member)*, impairments caused by disease *(such as poliomyelitis and bone tuberculosis)* and impairments from other causes *(such as cerebral palsy, amputations, and fractures or burns causing contractures).*

(6) *Visually Handicapped, Blind* — A visual acuity loss or deficit so severe that the person is impaired in processing information through sight, with or without any correction, to the extent that his or her educational performance is adversely affected.

(7) *Visually Handicapped, Partially Seeing* — A visual impairment that adversely affects a person's educational performance, but that does not constitute blindness.

(8) *Other Health Impaired* — Limited strength, vitality, or alertness due to chronic or acute health problems that adversely affect a person's educational performance, including heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle-cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, and diabetes.

b. *Speech/Language Impairment* — This group includes individuals exhibiting one or more of the following handicapping conditions that adversely affect their educational performance: voice production disorder, dysfluency, misarticulation, receptive language delay, expressive language delay.

c. *Learning Impairment* — This group includes individuals exhibiting one or more of the following handicapping conditions: generic, mild educational impairment; mentally retarded *(mild)*; mentally retarded *(moderate, severe)*; specific learning disability.

(1) *Moderate/Severe Mental Retardation* — The general intellectual functioning that is significantly subaverage. In addition to this intellectual deficit, these individuals are limited in, but able to acquire some academic material, care for their personal needs, and live independently as an adult. This condition is much less identifiable than the more seriously mentally disturbed.

(2) *Specific Learning Disabilities* — Disorder(s) in one or more of the basic psychological processes involved in understanding or in using spoken or written language that may manifest itself as an imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include people who have learning problems that are primarily the result of visual, hearing, or motor handicaps, mental retardation, emotional disturbance, or environmental, cultural, or economic differences.

d. *Seriously Emotionally Disturbed* — A condition that has been confirmed by clinical evaluation and diagnosis and that, over a long period of time and to a marked degree, adversely affects educational performance, and that exhibits one or more of the following characteristics: (1) An inability to learn that cannot be explained by intellectual, sensory, or health factors; (2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (3) Inappropriate types of behavior under normal circumstances; (4) A tendency to develop physical symptoms of fear associated with personal or school problems, or (5) A general pervasive mood of unhappiness or depression.

HEALTH-RELATED SURVEY – INDIVIDUAL FACILITY REPORT

For use of this form, see AR 608-1; the proponent agency is TAGO.

OMB APPROVED NO. 0704-0175

NOTE: This form will be completed by each individual facility indicating the capability of the facility to provide health-related services. Use typewriter or print legibly in ink.
READ THE DEFINITIONS ATTACHED TO THIS FORM BEFORE MAKING EACH ENTRY.

SECTION I – GENERAL INFORMATION

1. NAME OF FACILITY	2. ADDRESS		
3. CHIEF ADMINISTRATOR	4. BUSINESS TELEPHONE	5. SERVICE HOURS *(Days)* *(Hours)*	6. APPROXIMATE MILES FROM INSTALLATION

7. TYPE OF OWNERSHIP *(Indicate the category which best describes the legal ownership of this facility.)* *(Check one box only)*

☐ Private – for Profit ☐ Private – not for profit
☐ Local Government ☐ State Government ☐ Federal Government
☐ Other *(Specify)*

8. ACCESSIBILITY

a. TRANSPORTATION *(Check all that applies and fill in blanks)*

☐ On bus line ☐ Not on bus line; distance to bus line is _____ blocks
☐ Parking available (_____ miles) ☐ Parking fee $_____.
☐ *Taxi stand at facility* ☐ Facility operates own transportation system

b. WHEELCHAIR ACCESS *(Check all that applies)*

☐ Building
☐ Restrooms

9. FEE FOR SERVICE *(Check all that applies)*

☐ Full Fee ☐ *No Fee* ☐ Sliding Scale
☐ Advance Pay ☐ Medicaid ☐ CHAMPUS
☐ Private Health Insurance ☐ Other

☐ Unrestricted
☐ Restricted *(Specify age group)* _____

SECTION II – HEALTH-RELATED SERVICE ASSISTANCE LEVEL CAPABILITY

a. In Items 1 through 8 below, indicate whether or not your facility has vacancies during the next year for new patients in the category and level applicable to the specified age groups.

LINE	FUNCTIONAL CATEGORIES	LEVEL A				LEVEL B				LEVEL C				LEVEL D				LEVEL E			
		YOUTH		OTHER		YOUTH		OTHER		YOUTH		OTHER		YOUTH		OTHER		YOUTH		OTHER	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
1	Oral Motor Deficit																				
2	Compromised Respiratory Function																				
3	Restricted Mobility																				
4	Upper Extremity Deficit																				
5	Activities of Daily Living																				
6	Adaptive Equipment																				
7	Behavioral and Emotional Disorders																				
8	Drug and Alcohol Use/Abuse/ Dependence																				

SECTION II – HEALTH-RELATED SERVICE ASSISTANCE LEVEL CAPABILITY *(CONTINUED)*

b. In items 9 through 20 below indicate whether or not your facility has vacancies during the next year for new patients in the category and level specified below.

LINE	FUNCTIONAL CATEGORIES	LEVEL A		LEVEL B		LEVEL C		LEVEL D			
		YES	NO	YES	NO	YES	NO	YES	NO		
9	High Risk Newborn										
10	Delayed Development										
11	Delayed Cognitive Development										
12	*Sensory* Integration Deficit										
13	Architectural and Environmental *Adaptations*										
14	Vision										
15	Speech/Language Deficit										
16	Hearing										
17	Learning Problem										
18	Medical Social Work										
19	Community Health Nurse										
20	*Secondary Functional* Disabilities										

SECTION III – HOME OR NEAR HOME *(EXCLUDING SCHOOL BASED SERVICES)* SPECIAL CARE HEALTH-RELATED SERVICE ASSISTANCE LEVEL CAPABILITY

NOTE: Indicate whether or not your facility has vacancies for new patients for each type and level during the next year.

LINE	TYPES OF CARE	LEVELS OF CARE																	
		RESPITE CARE				DAY CARE				SHELTERED WORKSHOP				GROUP HOME				HOMEMAKER ASSISTANCE	
		YOUTH		OTHER		YOUTH		OTHER		YOUTH		OTHER		YOUTH		OTHER		YES	NO
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
21	Mentally Handicapped																		
22	Physically Handicapped																		
23	Psychiatric Care																		
24	Delinquency																		
25	Blind																		
26	Deaf																		

SECTION IV – HEALTH CARE PROVIDER SPECIALTY CAPABILITY

NOTE: Indicate the capability of your facility to provide health-related services in the categories shown below.

LINE	CATEGORY	YES	NO	LINE	CATEGORY	YES	NO	LINE	CATEGORY	YES	NO
27	*Allergist*			47	*Ophthalmologist, pediatric*			66	*Dentist*		
28	Cardiologist, pediatric			48	Otorhinolaryngologist			67	Pedodontist		
29	Dermatologist			49	Pediatrician			68	Oral Surgeon		
30	Endocrinologist			50	Developmental pediatrician			69	Orthodontist		
31	Endocrinologist, pediatric			51	Psychiatrist			70	Psychologist		
32	Gastroenterologist			52	Child Psychiatrist			71	Child psychologist		
33	Hematologist			53	Physical medicine physician/physiatrist			72	Neuropsychologist		
34	Hematologist, pediatric			54	Physical medicine physician/ physiatrist, pediatric			73	Audiologist		
35	Immunologist			55	Pulmonary disease physician			74	Physical therapist		
36	Internist			56	Rheumatologist			75	Physical therapist, pediatric		
37	Maxillofacial surgical team			57	Cardiac surgeon			76	Occupational therapist		
38	Nephrologist			58	General surgeon			77	Occupational therapist, pediatric		
39	Nephrologist, pediatric			59	Neurosurgeon			78	Respiratory therapist		
40	Neurologist			60	Orthopedic surgeon			79	Speech/language pathologist		
41	Neurologist, pediatric			61	Orthpedic surgeon, pediatric			80	Optometrist		
42	Nuclear medicine physician			62	Pediatric surgeon			81	Developmental optometrist		
43	Obstetrician and Gynecologist			63	Plastic surgeon			82	Orthotist		
44	Oncologist			64	Thoracic surgeon			83	Dietitian-nutritionist		
45	Oncologist, pediatric			65	Urologist			84	Podiatrist		
46	Ophthalmoloigst										

TYPED NAME OF INDIVIDUAL COMPLETING REPORT	SIGNATURE	COMMERCIAL TEL. NO.
		AUTOVON NO.

DEFINITIONS OF HEALTH-RELATED SERVICE ASSISTANCE LEVELS
AND
HOME OR NEAR HOME SPECIAL CARE LEVELS
DA FORM 4723-2-R

Levels of Health-Related Service Assistance

	LEVEL A	LEVEL B	LEVEL C	LEVEL D
1. Oral Motor Deficit *(therapy provided by a specially trained occupational therapist (OT), physical therapist (PT) or speech language pathologist (SLP) to improve skills of speaking, sucking, swallowing and eating)*				
a. Youth *(age 13 & under)*	Requires consultation to pediatric PT/OT and/or SLP.	Oral motor skills are not optimal. One session per week of oral motor therapy is required as a short term therapy plan.	*Oral motor dyspraxia is significant* and prevents normal acquisition of oral motor skills. Requires individual oral motor therapy one to two times per week as a long term ther· ·lan.	
b. Other *(over 13 years of age)*	Same level as for children except consultation/ therapy provided by adult PT/OT and/or SLP.	Same level as for children except consultation/ therapy provided by adult PT/OT and/or SLP.	Same level as for children except consultation/ therapy provided by adult PT/OT and/or SLP.	
2. Compromised Respiratory Function				
a. Youth *(age 13 & under)*	Basic management by pediatrician or internist with patient therapy by physical therapist with routinely available respiratory equipment such as handheld spirometer. *(PEDIATRIC TRAINED SPECIALIST)*	Must be managed by subspecialty trained pediatrician/internist. Requires hospital based respiratory therapist and facilities or intensive ventilatory support. *(PEDIATRIC TRAINED SPECIALIST)*		
b. Other *(over 13 years of age)*	Basic management by pediatrician or internist with patient therapy by physical therapist with routinely available respiratory equipment such as handheld spirometer. *(ADULT TRAINED SPECIALIST)*	Must be managed by subspecialty trained pediatrician/internist. Requires hospital based respiratory therapist and facilities or intensive ventilatory support. *(ADULT TRAINED SPECIALIST)*		

	LEVEL A	LEVEL B	LEVEL C	LEVEL D
Restricted Mobility *(musculoskeletal, neuromuscular, or cardiopulmonary conditions affecting bed mobility, transfers, wheelchair management and/or household or community ambulation skills)*				
a. Youth *(age 13 & under)*	Consultation by PT and/or physiatry or periodic monitoring of skills. *(PEDIATRIC TRAINED SPECIALIST)*	Short term PT 1-2 hours per week with decrease in frequency as mobility skills are mastered. *(PEDIATRIC TRAINED SPECIALIST)*	Long-term PT 1-2 sessions per week. Periodic consultation with physiatrist. *(PEDIATRIC TRAINED SPECIALIST)*	Intensive rehabilitation with PT 1-2 sessions per day. (PEDIATRIC *TRAINED SPECIALIST)*
b. Other *(over 13 years of age)*	Consultation by PT and/or physiatry or periodic monitoring of skills. *(ADULT TRAINED SPECIALIST)*	Short term PT 1-2 hours per week with decrease in frequency as mobility skills are mastered. *(ADULT TRAINED SPECIALIST)*	Long-term PT 1-2 sessions per week. Periodic consultation with physiatrist. *(ADULT TRAINED SPECIALIST)*	Intensive rehabilitation with PT 1-2 sessions per day. *(ADULT TRAINED SPECIALIST)*
4. Upper Extremity Deficit *(to include decreased range of motion, strength, dexterity, or coordination and/or alterations in tactile or proprioceptive sensation)* Ex. burns, orthopedic conditions, peripheral or CNS nerve involvement or dermatologic connective tissue conditions.				
a. Youth *(age 13 & under)*	Infrequent PT and/or OT consultation to family, patient, and/or school to maintain and/or improve skills. *(PEDIATRIC TRAINED SPECIALIST)*	Frequent PT and/or OT 1-2 sessions per week with decrease in frequency expected after approximately 6 months or as skills are mastered. *(PEDIATRIC TRAINED SPECIALIST)*	Ongoing PT and/or OT 1-2 sessions per week to improve or maintain skills on long term basis. May require consultation to other disciplines. *(PEDIATRIC TRAINED SPECIALIST)*	Ongoing intensive PT and/or OT, requires therapy greater than two sessions per week with consultation to physiatrist. *(PEDIATRIC TRAINED SPECIALIST)*
b. Other *(over 13 years of age)*	Infrequent PT and/or OT consultation to family, patient, and/or school to maintain and/or improve skills. *(ADULT TRAINED SPECIALIST)*	Frequent PT and/or OT 1-2 sessions per week with decrease in frequency expected after approximately 6 months or as skills are mastered. *(ADULT TRAINED SPECIALIST)*	Ongoing PT and/or OT 1-2 sessions per week to improve or maintain skills on long term basis. May require consultation to other disciplines. *(ADULT TRAINED SPECIALIST)*	Ongoing intensive PT and/or OT, requires therapy greater than two sessions per week with consultation to physiatrist. *(ADULT TRAINED SPECIALIST)*

	LEVEL A	LEVEL B	LEVEL C	LEVEL D
-5 Activities of Daily Living *(includes dressing, bathing, eating, self-care skills, use of communication aids, adaptive skills necessary to function at home, school, or work place or prevocational training or assessment)*				
a. Youth *(age 13 & under)*	Infrequent consultation by OT to parents, patient, or school. *(PEDIATRIC TRAINED SPECIALIST)*	Frequent occupational therapy 1-2 sessions per week with decrease expected after 6 months or as skills are mastered. *(PEDIATRIC TRAINED SPECIALIST)*	Ongoing occupational therapy 1-2 sessions per week as long term plan. *(PEDIATRIC TRAINED SPECIALIST)*	Ongoing intensive occupational therapy. *(greater than 2 sessions per week) (PEDIATRIC TRAINED SPECIALIST)*
b. Other *(over 13 years of age)*	Infrequent consultation by OT to parents, patient, or school. *(ADULT TRAINED SPECIALIST)*	Frequent occupational therapy 1-2 sessions per week with decrease expected after 6 months or as skills are mastered. *(ADULT TRAINED SPECIALIST)*	Ongoing occupational therapy 1-2 sessions per week as long term plan. *(ADULT TRAINED SPECIALIST)*	Ongoing intensive occupational therapy *(greater than 2 sessions per week) (ADULT TRAINED SPECIALIST)*
6. Adaptive Equipment				
a. Youth *(age 13 & under)*	Requires adaptive equipment devices readily available through MTF or local community. PT and OT counseling on use but no individual modification of device is needed. Ex: walkers, grab bars. *(PEDIATRIC TRAINED SPECIALIST)*	Requires adaptive equipment not routinely available but can be ordered by staff at MTF. Requires periodic adjustment or individual adaptation. Requires PT, OT, brace shop, orthopedic surgeon and /or physiatrist to monitor progress. Ex. resting/protective hand splints, functional and self-care aids requiring individual modification, spinal bracing, ankle-foot orthoses. (PEDIATRIC TRAINED SPECIALIST)	Requires specially designed and fitted equipment with special fabrication skills needed. Provision for close monitoring by physiatrist, orthopedic surgeon, OT, PT, and/or brace shop may be needed. May require OT and PT initially to use equipment. Ex: serial splinting, serial casting, knee-ankle-foot orthoses, prosthetics. *(PEDIATRIC TRAINED SPECIALIST)*	Requires or will require complete evaluation for adaptive equipment by physiatrist, OT, PT and/or orthopedic surgeon. Ex. newborn with limb deficiency, ambulatory preteen patient with muscular dystrophy. *(PEDIATRIC TRAINED SPECIALIST)*
b. Other *(over 13 years of age)*	Requires adaptive equipment devices readily available through MTF or local community. PT and OT counseling on use but no individual modification of device is needed. Ex. walkers, grab bars. *(ADULT TRAINED SPECIALIST)*	Requires adaptive equipment not routinely available but can be ordered by staff at MTF. Requires periodic adjustment or individual adaptation. Requires PT, OT, brace shop, orthopedic surgeon and/or physiatrist to monitor progress. Ex: resting/protective hand splints, functional and self-care aids requiring individual modification, spinal bracing, ankle-foot orthoses. *(ADULT TRAINED SPECIALIST)*	Requires specially designed and fitted equipment with special fabrication skills needed. Provision for close monitoring by physiatrist, orthopedic surgeon, OT, PT, and/or brace shop may be needed. May require OT and PT initially to use equipment. Ex: serial splinting, serial casting, knee-ankle-foot orthoses, prosthetics. *(ADULT TRAINED SPECIALIST)*	Requires or will require complete evaluation for adaptive equipment by physiatrist, OT, PT and/or orthopedic surgeon. Ex: newborn with limb deficiency, ambulatory preteen with muscular dystrophy. *(ADULT TRAINED SPECIALIST)*

	LEVEL A	LEVEL B	LEVEL C	LEVEL D	LEVEL E
7. Behavioral and Emotional Disorders *(including but not limited to anxiety, attention deficit, functional encopresis or enuresis, oppositional and conduct disorders, stereotyped movement disorders, phobic disorders, affective disorders, pervasive developmental disorders, and psychosocial causes for failure-to-thrive or developmental delay)*					
a. Youth *(age 18 & under)*	Primary care physician can manage alone or with occasional consultation to a child guidance team *(child psychiatrist, child psychologist, and child and family social worker, with consultation capability to occupational therapy, speech therapy, and developmental pediatrics).*	Evaluation and management is needed by a child guidance team for short term therapy with referral back to the primary physician for continued monitoring.	Long term outpatient management by the child guidance team. No hospitalization is anticipated.	Short term inpatient milieu management is anticipated or may be required.	A residential treatment program or long term inpatient care is anticipated or required
b. Other *(over 18 years of age)*	Primary care physician can manage alone or with occasional consultation to an adult mental health service.	Evaluation and management is needed by an adult mental health service for short term therapy with referral back to the primary physician for continued monitoring.	Long term outpatient management by an adult mental health service. No hospitalization is anticipated.	Short term inpatient milieu management is anticipated or may be required.	A residential treatment program or long term inpatient care is anticipated or required

	LEVEL A	LEVEL B	LEVEL C	LEVEL D
Drug and Alcohol Use/ Abuse/Dependence				
a. Youth *(age 18 & under)*	Concern or suspicion expressed by family, school, or neighborhood. Requires limited short term consultation with age appropriate psychologist or psychiatrist. *(PEDIATRIC TRAINED SPECIALIST)*	Confirmed use exists. Requires exam by primary care provider followed by evaluation by age appropriate psychiatrist or psychologist, and three to six months individual and family therapy. *(PEDIATRIC TRAINED SPECIALIST)*	Serious abuse pattern exists, or dependence. Requires exam by primary care provider, evaluation by age appropriate psychiatrist and consideration of hospitalization for controlled intervention. Must then proceed with several months individual and family therapy. *(PEDIATRIC TRAINED SPECIALIST)*	Very serious repetitive problems exist, refractory to therapy. Requires consultation with age appropriate psychiatrist and consideration of removal from home and placement in mid to long term residential rehabilitation facility or enrollment in very intense outpatient individual and family community program. *(PEDIATRIC TRAINED SPECIALIST)*
b. Other *(over 18 years of age)*	Concern or suspicion expressed by family, school, or neighborhood. Requires limited short term consultation with age appropriate psychologist or psychiatrist. *(ADULT TRAINED SPECIALIST)*	Confirmed use exists. Requires exam by primary care provider followed by evaluation by age appropriate psychiatrist or psychologist, and three to six months individual and family therapy. *(ADULT TRAINED SPECIALIST)*	Serious abuse pattern exists, or dependence. Requires exam by primary care provider, evaluation by age appropriate psychiatrist and consideration of hospitalization for controlled intervention. Must then proceed with several months individual and family therapy. *(ADULT TRAINED SPECIALIST)*	Very serious repetitive problems exist, refractory to therapy. Requires consultation with age appropriate psychiatrist and consideration of removal from home and placement in mid to long term residential rehabilitation facility or enrollment in very intense outpatient individual and family community program. *(ADULT TRAINED SPECIALIST)*
9. High Risk Newborn *(0-18 months)*	Follow-up by the neonatologist, general practitioner with special attention to possible developmental problems. Consultation with pediatric physical therapist *(PT)** and/or developmental pediatrician at six month intervals.	Follow-up by pediatric PT* and developmental pediatrician at regular intervals *(every 2-4 months)* during the first 18 months of life. Consultation to audiologist/ speech language pathologist *(SLP)* and child resource team as needed.	Follow-up by pediatric PT* and developmental pediatrician at frequent intervals *(every month)* during the first 18 months of life. Consultation to audiologist/SLP and child resource team as needed.	An abnormality of movement or tone exists. Pediatric PT* is indicated once or twice a week. Follow-up by developmental pediatrican, audiologist, SLP and/or child resource team will be frequent.
10. Delayed Development	Suspicion or at risk for developmental delay. Requires a 3-6 month evaluation by a pediacian.	Developmental delay has been diagnosed with early cognitive enrichment recommended *(public school or community based)*. Follow-up by pediatrican, pediatric PT/OT, audiologist/ SLP and optometrist with annual review by child resource team.	Developmental delay diagnosed. Follow-up by pediatric PT/OT at regular intervals *(every four months or less)*. Child resource team required *(every four months or less)*.	Requires cognitive enrichment and pediatric PT/OT services. Requires integrated program where the PT/OT works with the preschool special education teacher and the parents.
11. Delayed Cognitive Development *(over 6 years of age)*	Can be followed by primary care physician with occasional consultation to general pediatrician or family practitioner.	Requires frequent follow-up by pediatrician or family practitioner for social, psychological, school and family issues.	Requires primary care by full child resource team.	Requires residential care.

*If pediatric PT is not available, management may be provided by a pediatric OT.

	LEVEL A	LEVEL B	LEVEL C	LEVEL D
Sensory-Integration Deficit *(deficit in the way sensations are coordinated, filtered, and interpreted in relationship to an individual's need to perceive and act in response to the human and non-human environment)*	Requires pediatric OT consultation to the teacher, weekly group OT, or a monitored home program.	Requires individual pediatric OT one-two hours per week.	Requires individual pediatric OT greater than two hours per week.	
13. Architectural and Environmental Adaptations	Due to decrease in endurance, strength, bilateral coordination or unilateral deficits, requires adaptations such as limited steps, grab bars, adjusted door handles, phone and water fountains at appropriate height, elimination of heavy doors at work, home, and school. Ex: those patients with hemiplegia, bilateral upper extremity involvement, decreased endurance secondary to respiratory or cardiac conditions.	Predominantly or completely wheelchair dependent. Must have complete wheelchair access to home, school and work environment.	Requires environmental adaptations for the blind.	Requires environmental adaptations for the deaf.
14. Vision	Requires routine eye examination for glasses and ocular health for an annual basis.	Requires evaluation for low vision aid or medically indicated contact lenses.	Requires 1-2 times per year evaluation for eye tracking, focussing, binocular or developmental vision difficulty by optometrist.	Requires special care for optometric or ophthalmologic needs.
15. Speech/Language Deficit	Initial management by SLP on a weekly basis with therapy likely to be short term.	Requires regular therapy on a weekly basis as a long term therapy plan.	Requires a program to facilitate functional communication.	
16. Hearing	Requires continued audiometric monitoring.	Requires evaluation, fitting, habilitation/rehabilitation with hearing aid*(s)*.	Residential program for the deaf.	
17. Learning Problem	An educational diagnostic team *(including reading specialist, speech and language specialist, curriculum specialist, school psychologist, school social worker, and special education teacher)* is needed for initial evaluation and re-evaluation at a minimum of every three years.	An educational team *(including school psychologist, school social worker, and special education teacher)* is needed to define special classroom techniques, teaching modifications, and special equipment needs for educational advancement.	An educationally oriented vocational rehabilitation program is needed for a mentally, emotionally and/or physically handicapped individual. This includes both evaluation and program monitoring that may interface with hospital based resources.	In addition to educational diagnostic team, requires child psychiatrist or a medically based clinical psychologist for evaluation/re-evaluation. This category includes preschool children with complex handicapping conditions, or school aged children or adults who have significant medical or neurological disease, or in whom there is a large emotional component to performance problems at school/home/work.

	LEVEL A	LEVEL B	LEVEL C	LEVEL D
18. Medical Social Work	Can be managed by primary care provider with occasional referral to social work.	Services of social worker will be necessary on a regular basis.	Intensive social work intervention is likely.	Anticipate involvement with civil authorities *(ex: delinquency).*
19. Community Health Nurse	Infrequent visits *(1 per month or less).*	Visits from 1-4 times per month.	More than weekly visits to home, hospital, school, or work place.	
20. Secondary Functional Disabilities *(secondary to other chronic medical conditions such as asthma, diabetes, cystic fibrosis, juvenile rheumatoid arthritis, heart disease, etc.)* Use this category for disabilities not covered previously.	Can be managed by a primary care provider.	Requires close proximity to a community hospital.	Requires care of specialists normally found at medical centers.	Requires frequent use of resources of a major medical center.

Levels of Home or Near Home Special Care Health-Related Service Assistance

Respite Care

a. Youth *(age 18 & under)*
b. Other *(over 18 years of age)*

A program which locates and pays for trained "respite workers" who can competently care for a handicapped patient so that the family can have a few hours or days break in caring for the patient. Respite care may take place in the home of the patient or in the home of the respite worker.

Day Care

a. Youth *(age 13 & under)*
b. Other *(over 13 years of age)*

Sometimes also known as day treatment, a program whereby a patient can spend his/her days in a supervised environment and return to his/her own home at night. Often some medical, physical, or occupational treatment or counseling is available.

Sheltered Workshop

a. Youth *(age 18 & under)*
b. Other *(over 18 years of age)*

A program which provides supervised jobs for handicapped individuals.

Group Home

a. Youth *(age 18 & under)*
b. Other *(over 18 years of age)*

A day and night facility for patients with similar disabilities.

Homemaker Assistance

A program in which a trained homemaker comes to the client's home and teaches and assists in menu preparation, shopping, housekeeping, cooking, laundry, etc.

REPORT OF HEALTH-RELATED SERVICES FOR THE EXCEPTIONAL FAMILY MEMBER

For use of this form, see AR 608-1; the proponent agency is TAGO.

REQUIREMENT CONTROL SYMBOL AG-884

DATE OF REPORT

TO: *(Name of Major Command, State and ZIP Code)*

FROM: *(Name of Installation, State and ZIP Code)*

SECTION I – HEALTH-RELATED SERVICE ASSISTANCE LEVEL CAPABILITY

a. In items 1 through 8 below, indicate with a checkmark all categories and levels, applicable to the specified age groups for which vacancies are expected during the next year.

LINE	FUNCTIONAL CATEGORIES	LEVEL A		LEVEL B		LEVEL C		LEVEL D		LEVEL E	
		YOUTH	OTHER	YOUTH	OTHER	YOUTH	OTHER	YOUTH	OTHER	YOUTH	OTHER
1	Oral Motor Deficit										
2	Compromised Respiratory Function										
3	Restricted Mobility										
4	Upper Extremity Deficit										
5	Activities of Daily Living										
6	Adaptive Equipment										
7	Behavioral and Emotional Disorders										
8	Drug and Alcohol Use/Abuse/ Dependence										

b. In items 9 through 20 below, indicate with a checkmark all categories and levels for which vacancies are expected during the next year.

		LEVEL A	LEVEL B	LEVEL C	LEVEL D	
9	High Risk Newborn					
10	Delayed Development					
11	Delayed Cognitive Development					
12	Sensory Integration Deficit					
13	Architectural and Environmental Adaptations					
14	Vision					
15	Speech/Language Deficit					

SECTION I – HEALTH-RELATED SERVICE ASSISTANCE LEVEL CAPABILITY *(CONTINUED)*

LINE	FUNCTIONAL CATEGORIES	LEVEL A	LEVEL B	LEVEL C	LEVEL D	
16	Hearing					
17	Learning Problem					
18	Medical Social Work					
19	Community Health Nurse					
20	Secondary Functional Disabilities					

SECTION II – HOME OR NEAR HOME *(EXCLUDING SCHOOL BASED SERVICES)* **SPECIAL CARE HEALTH-RELATED SERVICE ASSISTANCE LEVEL CAPABILITY**

NOTE: Indicate with a checkmark all those types and levels for which vacancies are expected during the next year.

LINE	TYPES OF CARE	LEVELS OF CARE									
		RESPITE CARE		DAY CARE		SHELTERED WORKSHOP		GROUP HOME		HOMEMAKER ASSISTANCE	
		YOUTH	OTHER	YOUTH	OTHER	YOUTH	OTHER	YOUTH	OTHER	YES	NO
21	Mentally Handicapped										
22	Physically Handicapped										
23	Psychiatric Care										
24	Delinquency										
25	Blind										
26	Deaf										

SECTION III – HEALTH CARE PROVIDER SPECIALTY CAPABILITY

NOTE: Indicate with a checkmark if support is available. Leave blank if support is not available.

LINE	CATEGORY	√	LINE	CATEGORY	√	LINE	CATEGORY	√
27	Allergist		47	Ophthalmologist, pediatric		66	Dentist	
28	Cardiologist, pediatric		48	Otorhinolaryngologist		67	Pedodontist	
29	Dermatologist		49	Pediatrician		68	Oral Surgeon	
30	Endocrinologist		50	Developmental pediatrician		69	Orthodontist	
31	Endocrinologist, pediatric		51	Psychiatrist		70	Psychologist	
32	Gastroenterologist		52	Child Psychiatrist		71	Child psychologist	
33	Hematologist		53	Physical medicine physician/ physiatrist		72	Neuropsychologist	
34	Hematologist, pediatric		54	Physical medicine physician/ physiatrist, pediatric		73	Audiologist	
35	Immunologist		55	Pulmonary disease physician		74	Physical therapist	
36	Internist		56	Rheumatologist		75	Physical therapist, pediatric	
37	Maxillofacial surgical team		57	Cardiac surgeon		76	Occupational therapist	
38	Nephrologist		58	General surgeon		77	Occupational therapist, pediatric	
39	Nephrologist, pediatric		59	Neurosurgeon		78	Respiratory therapist	
40	Neurologist		60	Orthopedic surgeon		79	Speech/language pathologist	
41	Neurologist, pediatric		61	Orthopedic surgeon, pediatric		80	Optometrist	
42	Nuclear medicine physician		62	Pediatric surgeon		81	Developmental optometrist	
43	Obstetrician and Gynecologist		63	Plastic surgeon		82	Orthotist	
44	Oncologist		64	Thoracic surgeon		83	Dietitian-nutritionist	
45	Oncologist, pediatric		65	Urologist		84	Podiatrist	
46	Ophthalmologist							

TYPED NAME OF INDIVIDUAL PREPARING REPORT	SIGNATURE	COMMERCIAL TEL. NO.
		AUTOVON NO.

Headquarters
Department of the Army
Washington, DC
15 May 1983

*Army Regulation 608–1

Effective 15 June 1983

Personnel Affairs

Army Community Service Program

Summary. This regulation is a consolidation of the standards for service delivery in the Army Community Service (ACS) Program. It modifies the suggested organizational structure for ACS programs; deletes child support services (CSS) as an essential ACS program; changes the format and content of the ACS program report; and outlines requirements for a daily reporting system. This revision establishes ACS responsibilities for the Army's consumer affairs and family advocacy programs under the Department of Defense (DOD). It implements DOD Directives 5030.56 and 6400.1. While no new programs have been established, criteria for financial support, personnel functions and duties, and program requirements are expanded.

Applicability. This regulation applies to the Active Army. It also applies to the Army National Guard (ARNG) and the US Army Reserve (USAR) while on active duty.

Impact on New Manning System. This regulation contains information that affects the New Manning System. It establishes the requirement that ACS assists personnel and their families with premove and postmove briefings and other services designed to minimize personal and financial stress associated with unit rotation.

Supplementation. Supplementation of this regulation is prohibited without prior approval from The Adjutant General, ATTN: DAAG–PSC, ALEX VA 22331.

Interim changes. Interim changes are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested improvements. The proponent agency of this regulation is The Adjutant General's Office. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA(DAAG–PSC), ALEX VA 22331.

Contents

*This regulation supersedes AR 608–1, 1 October 1978, and AR 608–17, 31 March 1977.

Chapter 1
Program Management

Section I
General

1–1. Purpose
This regulation prescribes policies, responsibilities, and procedures for establishing and operating an Army Community Service (ACS) program at Army installations.

1–2. References
Required and related publications are listed in appendix A.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. ACS program objectives
The objectives of the ACS program are to—

a. Provide the installation commander with staff assistance in solving problems of the military community.

b. Improve the quality of life and the well-being of members of the command to include solving complex personal, family, and community social problems.

c. Serve as the commander's primary resource agency for the coordination, maintenance, and development of the installation soldier and family social support system.

d. Establish and develop a community-based program for services that foster the growth and development of children of families assigned to the installation.

e. Provide special services and assistance to married junior enlisted service members and their families for their adjustment to Army life. Assist them in maintaining their financial stability.

1–5. ACS program criteria
a. The installation ACS program.

(1) ACS programs will be established at installations that—

(*a*) Are not tenants or satellites of a host installation.

(*b*) Authorize families to join their sponsors.

(*c*) Have an installation or community population of 1,000 or more (DA Pam 570–551).

(2) ACS programs are strongly recommended and authorized at installations that may not meet one or more of the criteria in (1) above. They can be established if—

(*a*) Community health and welfare resources are limited.

(*b*) The complexity of social problems requires special programing.

(3) The installation ACS program should—

(*a*) Have a full-time and part-time ACS program staff.

(*b*) Be located in an area used exclusively for ACS program activities.

(*c*) Provide essential ACS programs according to local need (para 2–1).

(*d*) Have an ACS volunteer corps.

(4) The installation commander will designate an ACS officer to operate the ACS program.

b. The ACS point of contact (POC). Installation commanders who do not have an established ACS program will name an individual to be the POC for all matters regarding ACS program services. The POC will provide—

(1) Information about the installation to other ACS programs (para 5–4).

(2) Local referral assistance to service members and their families stationed at the installation.

1–6. Eligibility
a. In the continental United States (CONUS), the following personnel are eligible for ACS program assistance:

(1) Active duty and retired military personnel and their families.

(2) Members of the Reserve and National Guard Components on active duty or active duty for training and their families.

(3) DA civilians and their family members, if local civilian resources are not available. The local commander will determine the extent of services to be provided.

(4) Widows, widowers, and other next of kin of military personnel who were on active duty or retired at time of death.

(5) Next of kin of prisoner of war or missing in action (POW/MIA) personnel of all armed services.

b. In oversea commands, eligibility will be determined locally in accordance with international treaties and agreements.

1–7. Morale and welfare
a. Commanders have primary responsibility for readiness and preparedness of troops for missions crucial to national security. Military missions can be stressful to some service members and their families. To alleviate stress, commanders must address the morale and welfare of their commands. No other person or agency can assume this responsibility.

b. The ACS program is designed to assist commanders in supporting service members and their families. It identifies individual and community needs

and issues and coordinates community resources in meeting those needs and issues. Command commitment and involvement in ACS program activities are essential. This commitment will improve readiness, retention, and family support of service members' commitment to the Army.

c. ACS program personnel will work closely with local military and civilian social service agencies and their representatives to—

(1) Develop community resources.

(2) Make resources available to all military personnel and their families.

(3) Insure compliance with procedures established by community agencies.

d. ACS program personnel are encouraged to develop effective working relationships with civilian community agencies. Membership on various health, welfare, and social service committees, councils, and community planning organizations will help in this effort.

e. Written memorandums of understanding will show working relationships with civilian social service agencies.

f. ACS programs should be developed only when not available or accessible in the civilian community.

1–8. ACS program publicity

The installation ACS program will be publicized to make commanders, staff, service members, and their families aware of the types of services offered and the location of the ACS center. In coordination with the installation Public Affairs Officer (PAO), this can be done in several ways.

a. Use existing media (post newspaper, command information newsletter, installation bulletin, or troop topics).

b. Publish an ACS bulletin or newsletter.

c. Use signs to publicize ACS services. These signs should be posted at conspicuous places on the installation, such as the commissary and post exchange (PX) bulletin boards.

Section II
Responsibilities

1–9. The Adjutant General (TAG)

TAG has Headquarters, Department of the Army (HQDA), staff supervision over the ACS program. TAG will—

a. Establish and review Department of the Army (DA) policy on the ACS program.

b. Set professional standards for the operation of the ACS program.

c. Develop and implement a program evaluation system. This system will do the following:

(1) Assess service effectiveness and efficiency of overall ACS operations.

(2) Insure that results of the evaluation process are included in plans for program improvement and development of new programs.

d. Review proposals and statements of work for contracting the management and operations of ACS activities.

e. Analyze major Army command (MACOM) and installation ACS program reports and resource requirements.

f. Coordinate and submit ACS program resource requirements through budget channels.

g. Develop community needs assessments and methods to be implemented by each ACS program worldwide.

h. Visit, monitor, and provide technical assistance to MACOMs and installations with regard to their ACS programs.

i. Design and approve DA research studies and pilot projects related to the ACS program.

j. Fund and monitor the DA sponsored ACS course at the US Army Soldier Support Center, Fort Benjamin Harrison, IN.

k. Sponsor training workshops for MACOM and installation ACS personnel.

1–10. The Surgeon General (TSG)

TSG is responsible for the following:

a. Health aspects of the ACS program.

b. Providing the resources, professional services, and technical assistance required to support the ACS program.

c. Establish and maintain a central registry system for collecting and analyzing data on child or spouse maltreatment. This includes all resources and funding requirements needed to operate the system.

1–11. The Judge Advocate General (TJAG)

TJAG will provide advice, instruction, guidance, and assistance with legal aspects of the ACS program.

1–12. Chief of Engineers (COE)

COE will provide technical guidance on all engineer matters concerning ACS facilities. Facility plans and designs for new construction and renovation in excess of $50,000 must be coordinated between the COE; Chief, Community Services Division; TAGO Soldier/Family Assistance Directorate; and appropriate MACOM and installation program and engineering personnel.

1–13. Major Army commanders

MACOM commanders are responsible for the management and operational supervision of MACOM and installation ACS programs. They will—

a. Establish and review MACOM ACS program policy.

b. Analyze installation ACS program reports and resource requirements.

c. Coordinate and submit installation and MACOM ACS program resource requirements through budget channels to HQDA.

d. Allocate MACOM ACS program resources to installations.

e. Appoint ACS officers at installation and MACOM levels to supervise the program managers and coordinators. These persons should be of sufficient grade or rank, preferably 04 or above, and have appropriate military or civilian experience to perform effectively. Recommended tour for an ACS officer is at least 24 months (11 months in short tour areas). All ACS officers will be scheduled for the ACS course within 60 days of assuming duties. Officers selected to be an ACS officer in short tour oversea areas will be scheduled for attendance at the ACS course while en route to their new assignment.

f. Establish ACS staff positions at the MACOM level to manage and provide assistance effectively to ACS programs within the command.

g. Insure authorization and assignment of a professional installation staff for the ACS program.

h. Visit installations to assess their ACS program status and provide technical assistance.

i. Sponsor training workshops for installation ACS personnel.

j. Coordinate all pilot projects and research with HQDA(DAAG–PSC).

1–14. Installation commanders

Installation commanders are responsible for the management of their ACS programs. They will—

a. Identify community needs and resource requirements to their MACOMs.

b. Provide installation ACS program reports and resource requirements to their MACOMs.

c. Establish priorities and allocate resources to the installation ACS program to meet community needs.

d. Monitor and evaluate their ACS programs.

e. Insure that ACS officers at installation levels are appointed (para 1–13*e*).

f. Establish written memorandums of agreement and understanding between civilian social service agencies and ACS with guidance from JAG.

1–15. Installation ACS officers

ACS officers will operate the installation ACS program. They will—

a. Plan for and effectively use resources allocated to the installation ACS program.

b. Identify and report community needs and ACS program resource requirements to the installation commander.

c. Prepare the installation ACS program report and forward it to the installation commander. (See chap 10.)

d. Provide direct supervision of all ACS program coordinators, managers, volunteer supervisors, and subordinate staff.

e. Be responsible for recruiting, training, organizing, and supporting the ACS volunteer corps through its leadership.

f. Support the volunteer field consultant corps program.

1–16. ACS program points of contact

ACS points of contact (POC) (para 1–5*b*) receive and distribute information on ACS program services. They will—

a. Identify and report community needs to the installation commander.

b. Prepare the installation ACS program report and forward it to the installation commander. (See chap 10.)

Section III
Funding

1–17. ACS appropriations

a. The ACS program is established and operated as an appropriated fund (APF) activity. Nonappropriated funds (NAF) may be used to supplement APF. (See para 1–18.)

b. APF resource requirements (authorized by AR 37–100) for the ACS program will be considered with all other program requirements in installation and MACOM annual Program Analysis Resource Review (PARR) submissions.

c. MACOM and installation ACS program staff personnel will participate in budget planning. They will help to determine funding and staffing needed to operate their respective programs.

1–18. Financial support for the ACS program

a. APF support.

(1) APF will be administered in accordance with the AR 37 series.

(2) ACS volunteers may be issued Invitational Travel Orders authorized in Joint Travel Regulation (JTR), volume 2, part A, chapter 6.

(3) Common Table of Allowances (CTAs) for the ACS program authorize—

(*a*) Office furniture and equipment for ACS programs and facilities (CTA 50–909).

(*b*) Expendable and nonexpendable supplies and equipment for ACS (CTA 50–909, chap 7).

(*c*) Expendable and nonexpendable supplies and

equipment for the ACS lending closet (para 5–4c). (See CTA 50–909, chap 7, and CTA 50–970.)

(*d*) Items that have a unit cost of less than $100 and are not listed in section II of CTA 50–970. These items are authorized for procurement through local sources (CTA 50–970, app A).

(4) APF may be used for automatic data processing (ADP) support (AR 210–55). The development of ADP systems within ACS must be coordinated with the installation automation management office.

(5) APF may be used to buy books and subscribe to professional journals, periodicals, and films for ACS resource libraries.

b. Nonappropriated fund instrumentality (NAFI) support.

(1) A category VIII Supplemental Mission NAFI Fund may be established to serve as a part of the ACS program. This fund will be used to administer the receipt of voluntary gifts and donations from private sources (AR 1–100 and AR 1–101). It will also facilitate the authorized expenditure of NAF in support of ACS programs (AR 230–1) and when APF are certified not available.

(2) NAF may be used to purchase ACS awards, pins, year guards, uniforms, and emergency food locker items. (These items may be given free of charge.)

(3) Grants or loans of NAF to individuals are not authorized.

1–19. Commercial activities program

a. All ACS activities subject to review under the Army commercial activities program (CAP) must be reviewed.

b. MACOM and installation commanders must use the statement of work developed by HQDA(DAAG–PSC) as a guide in preparing their installation performance work statement.

c. The performance work statement and cost and management studies will be prepared in direct coordination with the ACS officer and program coordinators of each ACS activity.

d. Copies of all contracts for management and operation of ACS activities will be sent to HQDA(DAAG–PSC), ALEX VA 22331.

Chapter 2
Elements of the Installation Army Community Service Program

Section I
The Army Community Service Center

2–1. Establishing the ACS program

a. The ACS program is established to insure that specific services, considered essential to the life support of service members and their families, will be provided. Each ACS program established will be in accordance with paragraph 1–5*a*.The ACS program also provides installation commanders with flexibility to use the best way to supplement their ACS program and meet locally determined needs and priorities.

b. The installation ACS Program functional organization chart is at figure 2–1.

c. Child support services (CSS) are deleted as an essential ACS program. The child development services (CDS) remains an essential program for each installation. It may or may not be administered by ACS. Installation commanders may establish CDS as a separate program separate from ACS. If they establish a CDS program it should be considered an equivalent program to ACS and should be under the same organizational supervision as the ACS program.

2–2. Criteria for the ACS center

To meet the objectives of the ACS program, an ACS center must be established. The center should be easily accessible, centrally located, and housed in a single building when possible. It must be structured for ACS operations. It must include adequate work areas for staff and volunteers, and private areas for confidential interviews. (See DOD 4270.1–M for space allowances.) Hours of operation should be flexible enough for accessibility and reduction of time away from training and unit missions.

2–3. Identification of the ACS centers

a. All ACS program facilities must be easy to identify and locate.

b. The distinctive ACS emblem (fig 2–2) conveys the program's theme "Self-help, Service, and Stability." The emblem will be permanently displayed outside the ACS center so that it can be easily seen by personnel who wish to use ACS program services.

c. Identification signs should be prominently displayed on main roads on the installation to help newly assigned service members and their families locate the ACS center.

d. An ACS flag is authorized for display only in ACS centers and for use during ACS ceremonies and special events. The flag may be obtained by submitting funded MILSTRIP requisitions (AR 725–50) to the Defense Personnel Support Center (routing identifier S9T, NSN 8345–00–432–2714). APF are authorized for purchase of the flag.

2–4. ACS resource library

An ACS library will be established and maintained to include a collection of books, professional journals, periodicals, articles, newsletters, welcome packets, and films in all ACS program areas. APF may be used for purchase of items for the resource library.

Section II
Outreach Model

2–5. Goals

The goal of outreach is to provide service members and their families with responsive programs and services. Outreach provides service members with a sense of belonging to the military community and a means to improve the overall quality of their lives.

a. Effective service delivery requires matching the client's needs with the most appropriate service to meet those needs. To provide the most effective services to the greatest number of people, heaviest emphasis will be placed on providing outreach services. To achieve this objective, continuous attention must be given to identifying the following:

(1) Characteristics of the population served.

(2) Service requirements presented and those anticipated.

(3) Target populations that would appear to need but do not use ACS program services.

b. Essential programs in the installation ACS program will contain services that have outreach components servicing the needs of the community.

2–6. Priority among target populations

ACS program emphasis will be given to outreach components of those services for the following eligible target populations (listed in the descending order of priority):

a. Junior enlisted personnel and their families living off-post.

b. Junior enlisted personnel and their families living on-post.

c. Isolated or separated families and next of kin of POW/MIA personnel.

d. All active duty service members and their families assigned to the US Army Recruiting Command (USAREC).

e. All active duty service members and their families assigned to the US Army Reserve Officer Training Corps (ROTC).

f. All active duty service members and their families assigned to the US Army readiness and mobilization regions and groups.

g. All other active duty service members and families living off-post.

h. All other active duty service members and their families living on-post.

i. Military retirees and their families, unremarried widows or widowers, and other next of kin of deceased retired or former active duty personnel.

j. All other eligibles living on-post or off-post.

2–7. Provisions of services with outreach components

a. Each installation will decide, according to need and available resources, how to use the outreach component most effectively.

b. The following services will provide an outreach component:

(1) *Welcome visits.* Friendly and informative visits with newly arrived families both on-post and off-post to help them adjust to their new community. Welcome visits normally are conducted by volunteers from organizations on-post. These volunteers include wives clubs and units, organizations with clubs for spouses of assigned service members, sponsorship programs, and community life programs.

(2) *Welcome packets.* Welcome packets (para 5–4) may be distributed at facilities used by incoming personnel (e.g., inprocessing stations and guest houses). The packets may be sent to service members identified for transfer to the installation or distributed to them during home visits following relocation.

(3) *Community life program activities.* A community life program activity may be established to improve the quality of life of military personnel and their family members. Such a program will provide a channel for informing, planning, coordinating, and directing actions that will meet community needs. It will also allow personnel to become involved in community activities and management of the installation. A community life program can—

(*a*) Improve the flow of information between the community and the commander and staff.

(*b*) Provide recommendations to the commander in making decisions to improve community life and to inform the community of services available.

(*c*) Establish community organizations to assist in identifying community problems and needs.

(*d*) Expedite solving problems adversely affecting residents that communities are unable to solve.

(*e*) Improve community spirit and foster community activities by encouraging resident participation in community affairs.

(4) *Assistance to sole parents and inservice parents.* The problems experienced by sole parents or inservice parents are unique and may require special attention. ACS may develop programs or act as a liaison with commanders and other military and civilian agencies to mobilize resources to minimize stress and strengthen parenting skills. Such programs can increase service member's ability to respond to military requirements. These programs should include—

(*a*) Respite care.

(*b*) Community youth organizations.

(*c*) Family enrichment.

(*d*) Foster care.

(*e*) Child care.

(*f*) Foster grandparent care with senior civilian and military retiree participation.

(5) *Assistance to the unit commander.* He or she should be provided guidance and resources to help soldiers develop a support plan for family members during mobilization and unit deployment.

(6) *Orientation briefings.* Orientations and briefings for newly arrived personnel insures that essential information and assistance reaches these people. Commanders are encouraged to sponsor such gatherings for their personnel. When possible, family members should be asked to attend.

(7) *Provost marshal (PM) referral system.* Serious family problems often come to the attention of the installation military police. The ACS officer and PM must work out plans to be sure these problems are referred to ACS. This will allow use of the appropriate community services to reduce the seriousness of the situation.

Section III
Human Resource Council

2–8. Command coordination

Various activities exist on an installation to assist the commander in carrying out responsibilities to provide for the morale, health, and welfare of service members in the command. Many installation support activities provide services that have a direct impact on the well-being of service members and their families. Lack of coordination between these activities results in inefficient use of resources and poor service delivery.

2–9. Development of an integrated council system

a. There can be difficulties in coordinating morale, health, and welfare activities through normal command and staff channels. An "integrated council system" on

the scene can effectively enhance coordination of these activities if difficulties arise. To accomplish this—

(1) Commanders are strongly encouraged to establish and manage APF morale, health and welfare program councils on the installation.

(2) A council system should be structured on two functional levels.

(*a*) At the policy level, the Human Resource (HR) Council should be established. This single, broadbased installation community council should be oriented to policy development for the overall morale, health, and welfare service delivery system. Figure 2–3 shows a suggested composition of the HR Council.

(*b*) At the program level, various councils, task forces, or ad hoc committees should be established. These groups should be oriented to the internal policy and operational concerns of the specific programs they serve. The number and types of program councils would be determined by the installation commander.

b. Following adoption of the bilevel council system, policy functions of existing program councils dealing with morale, health, and welfare services would be referred to the HR Council. All new and existing program councils should be evaluated.

(1) The remaining functions of existing councils should be reviewed. Emphasis should be placed on the combination of similar functional areas among existing councils to reduce the number of these councils.

(2) The establishment of one program council to coordinate information and human service program delivery is strongly recommended. The ACS officer will provide recommendations on proposed program council composition to the installation commander.

(3) No new program councils should be formed unless existing counsels cannot reasonably absorb the critical functions of the new activity.

(4) The establishment of short term task forces or ad hoc committees is often more desirable than establishing and maintaining other new permanent councils.

2–10. Functions of the Installation Human Resource Council

The HR Council will—

a. Advise and assist the commander in the development of program policy for the morale, health, and welfare service delivery systems.

b. Provide a forum for the exchange of essential information among key personnel regarding soldier and family support systems.

c. Provide for command oversight and coordination of the morale, health, and welfare service delivery system.

d. Monitor the morale, health, and welfare service delivery system and make appropriate recommendations to the installation commanders. Insure efficient and effective service delivery for the installation community. These services can be provided by—

(1) Identifying problems in the delivery of services and by assisting in their solution.

(2) Improving coordination between agencies within the system to minimize duplication of effort and insure that proper and timely services are available to service members and their families.

(3) Identifying significant gaps in the service delivery system and recommending programs or services to remedy any problems.

e. Insure, through command and public information programs, that consumers are aware of issues and decisions that affect them; also, that mechanisms are available for their input.

f. Provide for the transmittal of information, suggestions, and concerns of community members regarding consumer-related issues.

g. Assist in reviewing and improving consumer education and information services.

h. Provide a forum for discussion of fees, entitlements, benefits, and changes to these items.

i. Evaluate and coordinate military and civilian consumer-related activities to insure that a comprehensive and integrated approach is taken to avoid fragmentation and duplication of services.

j. Provide plans and recommendations for the implementation of new services to meet changing consumer needs.

2–11. Council membership

a. The HR Council will be composed as a whole of full-time military and civilian employees of the Federal Government (fig 2–3). Exceptions to this are in AR 15–1 and other supplementary directives or regulations concerning organization of councils. Installation community members (e.g., volunteers, officer, and NCO wives' club representatives may attend council meetings and submit recommendations and information to the council.)

b. The HR Council will meet monthly or more often when directed by the installation commander.

2–12. Council leadership

a. Command involvement is essential for effective coordination within the installation council system. The Deputy Installation Commander (DIC) should chair the installation HR Council. If the installation does not have a DIC, the Director of Personnel and Community Activities (DPCA) should serve as chairperson.

b. An integrated program council should be chaired by the DPCA or a designated representative.

ACS PROGRAM FUNCTIONAL ORGANIZATION CHART

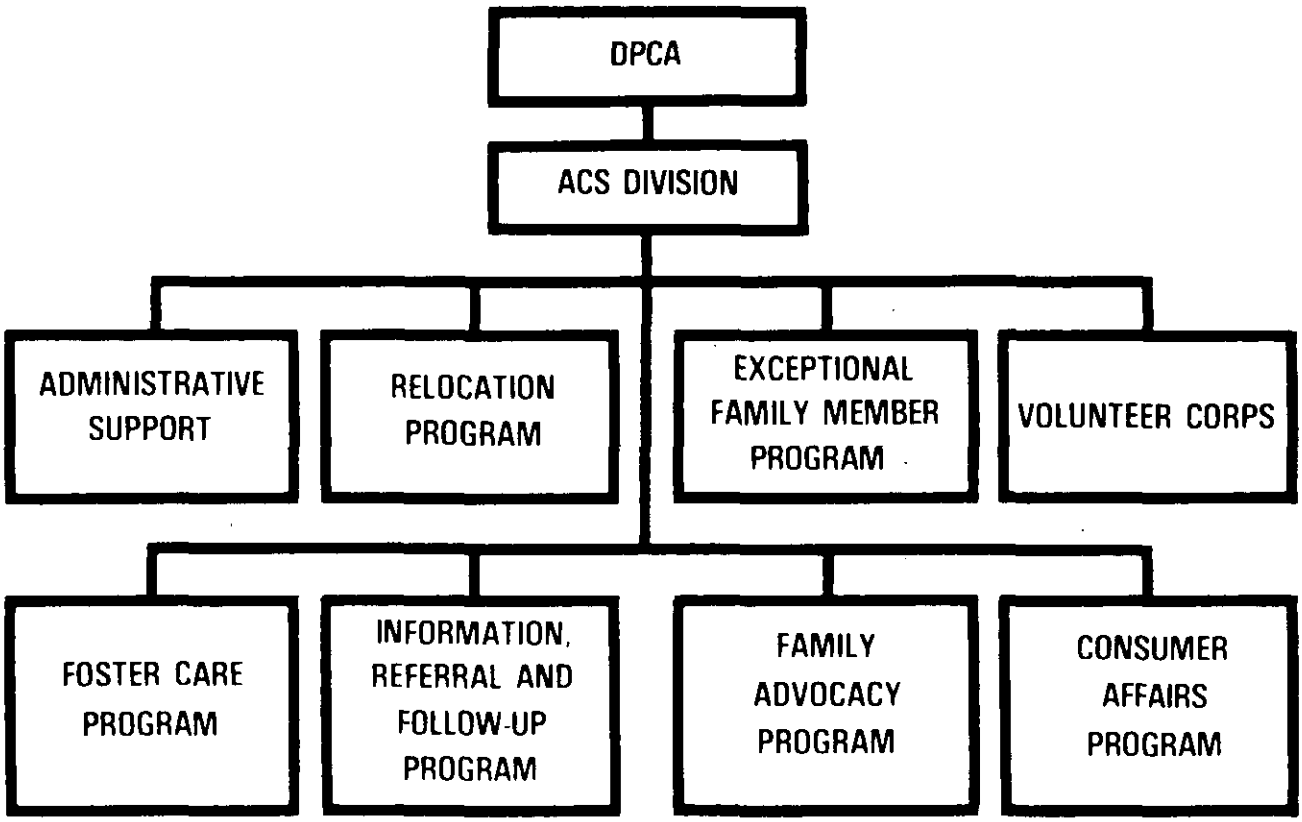
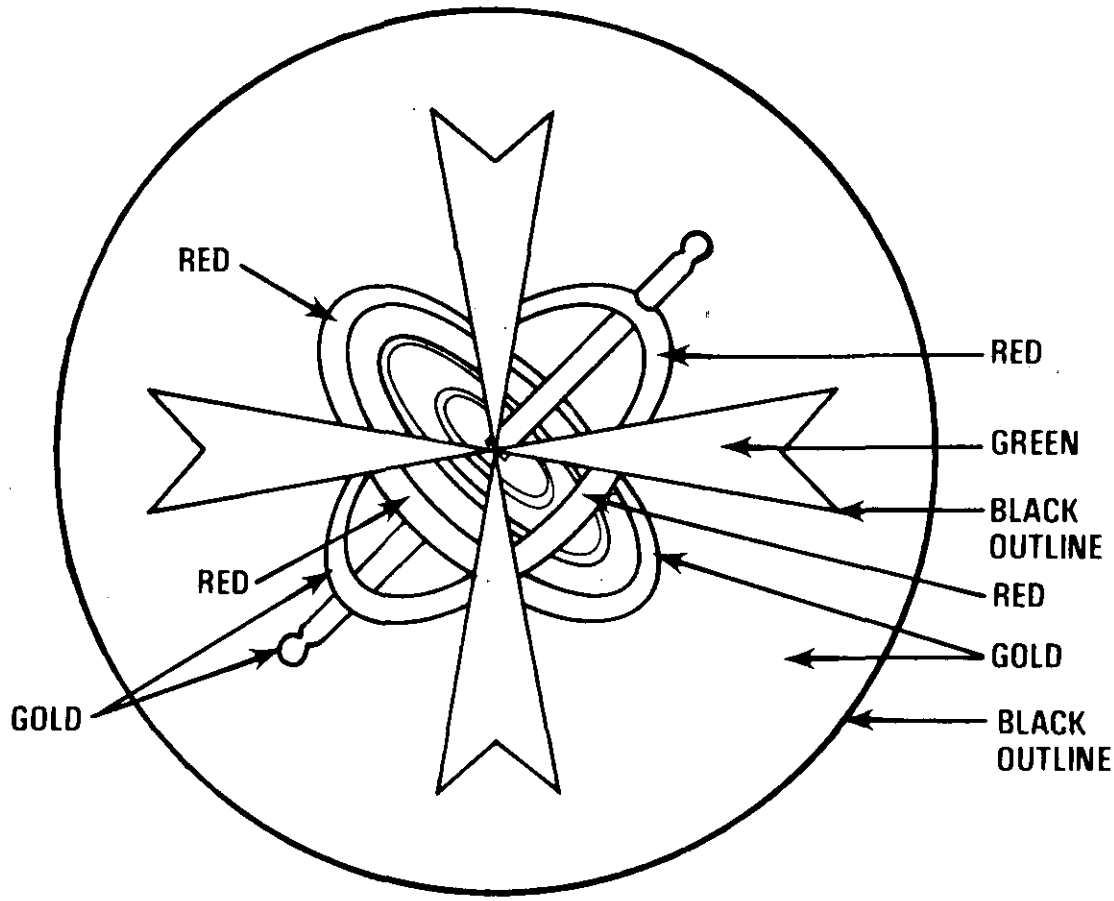


Figure 2–1. Organization chart

Theme: "Self-Help, Service, and Stability"



Legend: This emblem represents The Cross, The Gyroscope, and The Heart, an idea associated with the giving of kindhearted help and stability. The image of the cross is taken from an organization whose purpose, among other things, was to provide help for the sick and needy Crusaders during the Middle Ages. This may have been the first organized program of individualized relief services in relation to an Armed Force. The cross, a symbol for help, the gyroscope, a symbol for equilibrium and stability are combined with a heart to reflect the program as a living sustaining force in the lives of Army personnel and their dependents. The color of the Army green uniform and the gold buttons and insignia are combined in the emblem. The full circle represents the whole, or the Army Community.

Figure 2-2. Army Community Service Emblem

Commanders

Deputy installation commander (chairperson)
Major unit commanders (battalion level and higher)
Tenant unit commanders
Installation commander's sergeant major

Key Staff Officers

Safety officer
G1/Director of personnel and community activities
G4/Director of industrial operations
Adjutant general
Staff judge advocate
Provost marshal
Director of facilities engineering
Surgeon/Director of health services
Army Community Service officer
Chaplain
Public affairs officer
Comptroller representative
Civilian personnel officer
Organizational effectiveness officer
Director, Reserve Component

Morale, Health, and Welfare Program Principals

Community health nurse
Chief, social work service
Chief, Community mental health activity
Army Emergency Relief officer
Field director, American Red Cross
Equal opportunity staff officer
Alcohol and drug control officer
Morale support fund council representative
Housing officer
Morale support activities officer
Education officer
Schools officer
Chairperson, Family advocacy case management team
Military police youth and family service representative
Retired services officer
Child support services coordinator
Consumer affairs coordinator
Family advocacy program coordinator

Figure 2–3. Suggested membership for installation Human Resource Council

Chapter 3
Army Community Service Program Staff

Section I
Staffing

3–1. General

The ACS program staff discussed in this regulation refers to both paid and nonpaid military and civilian personnel.

a. The size of an installation ACS program staff will be based on the installation population served. Staff size will also depend on the degree of support available from the local civilian community, and the complexity and scope of services provided by the installation commander. (See DA Pam 570–551 for APF personnel staffing of ACS programs.) The ratio of paid and nonpaid staff will be determined at each installation. Overseas, where no civilian social services are available, staffing levels should be increased because of the absence of local community support. Recognition of the absence of extended family support networks in oversea areas necessitates command involvement in establishing family support programs.

b. Consistent with local service requirements and resources, professional personnel should be included on the ACS program staff to—

(1) Provide an interdisciplinary approach to the furnishing of direct services and in developing solutions to social and community problems.

(2) Insure that the social services provided are effective and of a high quality.

(3) Provide professional, administrative, and financial management expertise.

c. The military and civilian personnel assigned to staff positions should have mature judgment, interest, and skill in human relations. Those with backgrounds in social work, psychology, education, financial management, consumer affairs, and administration are particularly desirable.

d. All military, civilian, and key volunteer personnel assigned or volunteering services to the ACS program should have a knowledge of social welfare problems in the military community.

e. Installation ACS programs having a permanently assigned staff and a volunteer corps must have an ongoing training program. Training should include orientation, inservice training, and continuing education. This also includes professional workshops and conferences.

f. Guidelines for volunteer service will be maintained in each ACS center. Volunteer guidelines may be obtained by contacting HQDA(DAAG–PSC), ALEX VA 22331. These guidelines may be adapted to installation needs.

3–2. Key staff positions and major duties

a. ACS officer. The ACS officer will—

(1) Operate the ACS program according to this regulation and as directed by the installation commander.

(2) Maintain effective working relationships with commanders, staff agencies, and local civilian community health and welfare agencies.

(3) Supervise direct services provided in the program.

(4) Maintain a communitywide ACS information program to insure that unit commanders and their staff and all military personnel and their families, are aware of services offered.

(5) Manage and coordinate all aspects of the program including funding and resource management.

(6) Insure that a paid staff person is responsible for each program element.

(7) Where applicable, provide support for cohesive operational readiness training (COHORT) units.

b. Volunteer supervisor. The volunteer supervisor is responsible to the ACS officer for coordinating the volunteer corps. In coordination with appropriate staff members he or she will—

(1) Assist in recruiting and interviewing prospective volunteers for the ACS program.

(2) Assist in the development of an orientation and training program for volunteers.

(3) Assign volunteers to various committees based on their interests and talents, and with the concurrence of the supervising staff member and committee chairperson.

(4) Appoint committee chairpersons with concurrence of supervising staff member.

(5) Work with the assistant volunteer supervisor in maintaining accurate records of hours, training, and awards.

(6) Assist staff in organizing semiannual award ceremonies.

(7) Work with the staff and volunteers in evaluating the needs of the community and establishing new programs to meet those needs.

(8) Attend meetings with the local and military communities as required or requested to further community ties and help determine community needs.

(9) Attend regularly scheduled staff meetings.

(10) Conduct regular monthly meetings with the volunteer coordinating committee.

(11) Counsel volunteers when problems arise.

(12) Insure volunteer coordinating committee meeting minutes are prepared.

c. Assistant volunteer supervisor. The assistant volunteer supervisor will assist with the organization and development of the ACS volunteer program.

d. Social worker. The social worker will—

(1) Plan, develop, and implement community social service programs.

(2) Provide technical assistance in the development of programs.

(3) Provide community organization services and develop special oversea modes of service delivery.

(4) Insure that ACS staff members follow professional standards when providing social services.

(5) Maintain regular communication with representatives from other health and welfare agencies, including medical department activity (MEDDAC) and medical center (MEDCEN) social work service.

(6) If an ACS social worker is not assigned, the senior Army social work officer or regional social work consultant will provide technical consultation services.

e. Behavioral science specialist. The behavioral science specialist will—

(1) Conduct initial intake interview.

(2) Assist social work staff in providing short term crisis intervention counseling.

(3) Conduct briefings and training classes.

f. Administrative coordinator. The administrative coordinator will—

(1) Plan and coordinate procedures, methods, and workloads for efficient office operations.

(2) Prepare reports and insure ACS program compliance with regulations governing the use of APF and NAF.

g. Noncommissioned officer in charge (NCOIC). The NCOIC will—

(1) Serve as liaison for the enlisted community.

(2) Maintain recordkeeping and a functional file system.

(3) Supervise and provide guidance to enlisted personnel in the areas of military training, promotions, discipline, and proper military protocol.

(4) Coordinate the administrative operation of the entire ACS program.

(5) Assist the ACS officer and staff in developing budgets and preparing manpower justifications.

(6) Be responsible for the maintenance and security of ACS facilities.

h. Supply technician. The supply technician will—

(1) Supervise and maintain the lending closet operation.

(2) Establish and maintain property accountability of all ACS equipment (AR 710–2).

(3) Issue and maintain hand receipt of ACS equipment and supplies.

(4) Maintain and coordinate suspense system for lending closet and hand receipts.

i. Information and referral program coordinator. The information and referral program coordinator will—

(1) Manage and supervise the information and referral program.

(2) Provide preservice, on-the-job, and inservice training.

(3) Safeguard confidentiality in the areas of recordkeeping, reporting systems, and inquirer contact.

(4) Provide consultation services to civilian agencies that provide assistance to military families.

(5) Establish rapport and coordination with organizations that provide essential human services.

(6) Encourage participation in professional local, State and national organizations.

(7) Provide service-generated statistical data for planning purposes.

(8) Oversee the development and maintenance of a resource directory.

j. Consumer affairs program coordinator. The consumer affairs program coordinator will—

(1) Implement, manage, and supervise the consumer affairs program in accordance with this regulation.

(2) Develop a standard operating procedure (SOP) that outlines installation staff responsibilities for providing a consumer affairs program.

(3) Develop and coordinate an education program that includes mandatory inprocessing.

(4) Develop and publicize procedures for handling consumer complaints.

(5) Coordinate efforts with civilian consumer agencies and organizations to insure that DA programs—

(*a*) Complement other existing programs.

(*b*) Do not duplicate readily accessible services.

(6) Coordinate with various military activities implementing a comprehensive consumer advocacy program. Examples are such activities as the safety, staff judge advocate (SJA), public affairs (PA), procurement, and PM offices.

(7) Monitor the various installation level consumer advocacy agents to insure that they fulfill their responsibilities.

(8) Publicize consumer-oriented innovations as they occur at installations.

(9) Regularly provide consumers with information on health and safety issues regarding consumer products. Where the imminent safety of the consumer is at risk, this information will be immediately coordinated and made known.

(10) Be a member of the commissary and PX councils. The coordinator will be responsible for advising management on product selection, safety, adequacy of service, hours of operation, and consumer education programs. This will include patron requirements, suggestions, complaints, and areas of consumer satisfaction.

(11) Maintain case records for individuals or families receiving either debt liquidation or budget development assistance under file number 725–10 (AR 340–18–7).

k. Relocation program coordinator. The relocation program coordinator will—

(1) Manage and supervise the relocation program.

(2) Provide orientation briefings to newly arrived personnel regarding community resources.

(3) Supervise the lending closet operation.

(4) Conduct workshops for service members and families who are relocating.

(5) Assist installation commanders in establishing a family assistance plan during mobilization.

l. Exceptional family member program coordinator. The exceptional family member program coordinator will—

(1) Supervise exceptional family member program.

(2) Help families solve problems related to an exceptional family member's condition.

(3) Recognize handicapping conditions for children and adults; for example, severe, mild-moderate, and high-risk handicaps.

(4) Recognize and accept the needs and rights of exceptional family members.

(5) Work cooperatively with other professionals concerned with the services provided for exceptional children and adults. Actively participate in coordinated health, educational planning, placement, and followup.

(6) Develop and implement a public awareness program concerning the nature of disabling conditions and the availability of services.

(7) Plan and conduct recreational and cultural programs.

(8) Establish and administer a respite care program in coordination with the child support services (CSS) coordinator.

(*a*) Recruit, screen, train, and certify respite home caregivers.

(*b*) Establish intake procedures for the program.

(*c*) Coordinate the scheduling of families and caregivers.

(*d*) Document the scope of and need for service.

(9) Establish and maintain a card file and create an informational and support system among families of exceptional persons.

m. Family advocacy program coordinator. The family advocacy program coordinator will—

(1) Manage and supervise the Army Family Advocacy Program (AFAP) according to this regulation.

(2) Develop an SOP that outlines installation staff responsibilities for providing a family advocacy program.

(3) Develop and coordinate installation education programs to alert personnel that child and spouse maltreatment are serious problems.

(4) Develop and publicize procedures for reporting all incidents of child maltreatment.

(5) Establish procedures for liaison and referral with military and civilian health and human service agencies capable of assisting victims and perpetrators of child or spouse maltreatment.

(6) Assess and manage cases of child or spouse maltreatment in coordination with the family advocacy case management team (FACMT).

(7) Assure that support services such as temporary shelter and short term crisis intervention are accessible.

(8) Identify special needs of military families and help develop and coordinate activities and services that encourage the development of support systems.

(9) Develop and coordinate installation family enrichment or prevention programs designed to prevent child or spouse maltreatment.

n. Foster care program coordinator. The foster care program coordinator will—

(1) Establish and manage the installation foster care program in coordination with existing local civilian child welfare authorities.

(2) Assist installation commanders in establishing memorandums of agreement or understanding (chap 9).

(3) Establish definitions of emergency situations to guide staff in making placement decisions. Establish policies to insure that emergency placements do not continue beyond the emergency unless other factors intervene.

(4) Develop guidelines for placement.

(5) Insure the following actions are taken:

(*a*) Foster children, their parents, and foster parents are provided with written information stating their rights.

(*b*) The foster family services program is operated so that the rights of persons are protected and maintained.

(6) Insure that preplacement, placement, and postplacement services are provided to foster children and their families.

(7) Develop and implement a system to assure that appropriate foster family homes are available to meet a child's needs.

(8) Develop and implement policies and procedures to insure that planned services are provided to achieve goals for the child and family.

(9) Establish an objective case review system to assess service planning and delivery regularly, and the progress made toward achieving objectives for the child and family.

(10) Establish safeguards to insure confidentiality.

(11) Planning and implementing a public awareness program.

Section II
ACS Volunteer Corps

3–3. General

a. The ACS volunteer corps is composed of consultants at three command levels and includes an installation volunteer corps. Consultants serve at HQDA, MACOMs, and as volunteer field consultants. Installation corps include ACS volunteer supervisors, assistant supervisors, and committee members.

b. The mission of all elements of the volunteer corps is to support and lend strength to the ACS program by providing services to the installation community. The corps normally is composed of military family members. It may, however, include off-duty military personnel, teenage family members, retirees and their family members, or any interested civilian adults.

c. Commanders should actively encourage the recruitment, training, use, and retention of a volunteer corps. Such a corps provides participants with an opportunity to make a significant contribution to the military community. In addition, a well-organized and dedicated corps of trained volunteers also increases the efficiency and effectiveness of the installation ACS program. The volunteer corps should reflect a cross-section of the local military community (to include all pay grades and minority groups).

d. Each ACS volunteer is required to sign a DA Form 4712–R (Volunteer Agreement) annually. A file containing the signed volunteer statements will be maintained in the ACS center office. DA Form 4712–R will be reproduced locally on a 8- by 5-inch card. A copy for reproduction purposes is located at the back of this regulation.

e. Retired military members and their spouses are encouraged to serve as ACS volunteers.

3–4. Types of volunteer duty

a. Authorized duties include those that are not subject to classification by the Office of Personnel Management (OPM). Questions as to whether a position is classifiable should be addressed through channels to the Office of Personnel Management, 1900 E Street NW, WASH DC 20415, for review. The following duties are authorized:

(1) *Administrative.* Volunteers serve on committees and boards of directors, and participate in the planning and evaluation of specific programs and services. These volunteers work in tandem or partnership with the paid staff. In no case will they serve as final program planning or policy setting authority. Rather, they will serve as advisors on ACS programs and services. (An example is a youth advisory committee which serves to identify desirable recreational programs, activities, or services for young people.)

(2) *Operational.* Volunteers actually lead groups and assist and participate in program activities. Such duties can create a sense of involvement for both volunteers and participants. (Supervision is by qualified staff personnel.)

b. Duties not authorized are those duties that circumvent the civil service system by assigning volunteers to tasks fixed by statute. Volunteers or groups of volunteers must not be assigned responsibility for a major ACS program segment. This includes never being assigned as a manager, specialist, or technician.

3–5. Structure of the volunteer corps

a. The HQDA volunteer consultant and deputy consultant will be appointed by TAG on the recommendation of the Chief, ACS Division. Consultants will act as advisors and resource persons regarding volunteer matters.

(1) Selection of HQDA consultants will be based on the following criteria:

(*a*) A minimum of 5 years' experience as an ACS volunteer or other social service organization.

(*b*) A minimum of 1 year's experience as an ACS volunteer supervisor or consultant.

(*c*) Completion of basic installation ACS training, the ACS course, and attendance at a volunteer management workshop.

(*d*) Endorsement by ACS official staff supervisors and past ACS supervisors at both MACOM and installation level.

(2) HQDA consultants will—

(*a*) Assist in developing policy and procedures, and provide guidance to MACOM consultants on volunteer matters.

(*b*) Assume duties related to the state and development of volunteer programs. This includes participation in military and civilian workshops and conferences concerned with volunteer matters essential to ACS officials.

(*c*) Make public appearances or speaking engagements regarding volunteer matters on behalf of ACS.

(*d*) Assist in researching preparation of reports, articles, and other work important to the ACS volunteer mission.

(*e*) Work in the office at least 2 days a week.

b. The MACOM ACS volunteer consultant will be recommended by the ACS officer and appointed by the commander. Consultants will act as advisors and resource persons regarding volunteer matters for both the MACOM ACS officer and the MACOM commander. The consultant will also act as liaison between the HQDA volunteer consultant and the installation ACS.

(1) Selection of a MACOM consultant will be based on the following criteria:

(*a*) Minimum of 3 years' experience in the ACS programs, or other social service organization work

(*b*) Minimum of 1 year's experience as an ACS volunteer supervisor or assistant supervisor.

(*c*) Recommendation of most recent staff supervisor.

(2) Training will include ACS course attendance (if not previously completed), on-the-job training from the MACOM ACS officer, and volunteer management training.

(3) MACOM consultants will—

(*a*) Assist in developing volunteer policy, procedures, and guidance for the MACOM.

(*b*) Act as a trainer in volunteer program affairs.

(*c*) Monitor and assist with volunteer field consultant programs in their MACOM.

(*d*) Work in the office at least 1 day a week.

c. The ACS volunteer field consultant corps is established as an additional resource to provide training and technical assistance to the ACS program. Application for appointment to the field consultant corps will be through the recommendations of the installation ACS officer with concurrence of the MACOM volunteer consultant and ACS officer. Appointment will be made jointly by the HQDA volunteer consultant and the Chief, ACS Division. Appointed field consultants will act as resource persons to installations requesting assistance from their respective MACOM ACS officer or volunteer consultant.

(1) Volunteers applying for appointment to the field consultant corps will meet at least one of the following criteria:

(*a*) Minimum of 1 year's experience as an ACS volunteer supervisor. (The 1-year minimum can be lessened if the ACS officer recommends it.)

(*b*) Minimum of 1 year's experience as an assistant volunteer supervisor.

(*c*) Special skills of particular need for ACS programs.

(*d*) Former or retired military members and their spouses whose past ACS volunteer service included at least 1 year as a volunteer supervisor.

(2) Assignment of Field Consultants will be made by HQDA volunteer consultant through the MACOM consultant according to expertise, availability, and location to nearby military installations. The consultants will assume "active" status (ability to participate in active training or visitation) or "armchair" status (advisory status; consultation by correspondence or telephone).

(3) Field consultants will—

(*a*) Maintain a record of hours worked at the installation ACS located nearest his or her residence. Hours worked will be determined by the project requirements.

(*b*) Upon completion of each assignment, send after-action report through MACOM consultant to HQDA(DAAG-PSC), ALEX VA 22331.

(*c*) Notify HQDA and MACOM volunteer consultants of change of address.

(*d*) Upon departure, request that his or her hours be mailed to the receiving officer at a designated ACS center.

(4) All volunteer consultants will—

(*a*) Display a proven ability to work successfully with the public through personal contact, public speaking, and writing skills.

(*b*) Be available for a projected 1-year term, renewable by mutual consent of appointing official and volunteer consultant. (Field consultants are appointed for an indefinite term.)

(*c*) Maintain their own personnel file to include hours worked. They will encourage other volunteers to establish personnel files for career development purposes.

(*d*) Be provided uniforms by their respective headquarters. Field consultants will receive theirs from the nearest local installation.

(*e*) Receive logistical support from their respective headquarters. Field consultants will receive their support from the requesting local installation. (Invitational Travel Orders will be issued according to JTR, vol 2, part A, chap 6.)

(*f*) Be awarded the consultant pin. HQDA and MACOM consultants will also receive a rocker designating their assigned headquarters. (The consultant pin (heart enamel) is to be worn on right uniform collar of the outer garment, with the hours bar below and parallel to ACS pin on left collar). On termination of office, consultant is authorized to continue wearing heart enamel pin.

(*g*) Be awarded hours bar and year pins, certificates, letters of recommendation, commendation, or appreciation at semiannual award ceremonies. Special recognition ceremonies are at the discretion of the respective headquarters.

d. The installation volunteer supervisor and assistant supervisor will be selected by the ACS officer and volunteer corps. The primary concern in making selections will be the qualifications of candidates. The ACS officer will forward the names of selectees to the installation commander for appointment.

(1) The volunteer supervisor and assistant supervisor will normally serve for 1 year. The term may be renewed by mutual agreement of the ACS officer and volunteer.

(2) Overlap should be planned between the term of appointment for the volunteer supervisor and assistant supervisor.

e. The volunteer corps will be organized into committees working in ACS program elements under the supervision of a paid staff member. These committees will be organized on the program needs of the local installation.

f. The volunteer corps on each installation will be guided by the ACS volunteer coordinating committee.

(1) Membership of the committees will include the ACS officer, supervisor, assistant supervisor, chairpersons of each volunteer committee, and honorary volunteer advisors or their appointed representative.

(2) The committee will meet monthly and minutes will be prepared.

(3) Duties of the committee are as follows:

(*a*) Assist in the planning and scheduling of ongoing training.

(*b*) Request funding for volunteer projects.

(*c*) Recommend new volunteer programs.

(*d*) Insure that semiannual award ceremonies and recognition activities are scheduled. (Special recognition ceremonies are at the discretion of the ACS officer and volunteer supervisor.)

(4) Committee meetings will be chaired by the volunteer supervisor or assistant volunteer supervisor.

(5) Honorary volunteer advisors will sit on the committee as a representative of the commander. Customarily honorary volunteer advisors are the spouses of the commander and command sergeant major.

(6) If an honorary volunteer advisor chooses to appoint a representative, the person must meet one or more of the following criteria:

(*a*) Volunteer consultant, present or former.

(*b*) Volunteer field consultant, present or former.

(*c*) Former volunteer supervisor.

(*d*) A person with extensive volunteer experience with ACS or some other social service organization.

(7) Duties of the honorary volunteer advisor are—

(*a*) Attend monthly committee meetings.

(*b*) Be available for consultation with ACS staff, volunteer supervisor, and volunteer corps members.

(*c*) Speak in public when needed on behalf of ACS programs.

(*d*) Assist in recruiting appropriate volunteers based on vacancies of volunteer staff.

(*e*) Advocate ACS policies to community; reflect needs of community to ACS staff and volunteer coordinating committee.

3–6. Training

a. All ACS volunteers will participate in the ACS volunteer corps training program. Training will consist of—

(1) Initial and refresher orientation.

(2) On-the-job training.

(3) Continuing inservice training.

(4) Progressive senior management training.

b. The ACS officer has primary responsibility for organizing and directing volunteer training.

c. An ACS orientation course will be conducted in two phases.

(1) The first phase will be given to all new volunteers to the ACS program. This training will give ACS volunteers general, uniform, background information in the following subjects:

(*a*) The military family in the uniformed services.

(*b*) The mission of the ACS program in the US Army.

(*c*) The organization and functions of the installation ACS program.

(*d*) The role of the volunteer in the ACS program.

(*e*) Methods and techniques for effective volunteer service.

(2) The second phase will be given to all new volunteers and to ACS volunteers transferred to the installation from other ACS centers. Volunteers will receive specific information in the following subject areas:

(*a*) An overview of the conditions and problems unique to the installation community.

(*b*) A description of the services available to the military family on the installation and in the local civilian community.

d. It is important for the volunteer to perform duties on-the-job as soon as possible. Specialized programs of instruction will be developed to familiarize volunteers with the job responsibilities of chosen ACS programs. A concise but comprehensive orientation course is desirable.

e. As ACS volunteers gain knowledge and experience in the program, they may want to receive more technical and specialized training. An inservice training program will help improve the skill levels of the volunteer corps. It can also be used to provide individual volunteers with the skills training necessary to accept increasingly responsible challenges. Increased responsibility should be based on their demonstrated abilities and personal goals.

f. The ACS officer must insure that volunteers are thoroughly trained for their particular jobs and have a good working knowledge of the ACS mission and programs.

g. Command and staff elements are expected to contribute to the program in specialized areas of interest. Representatives of civilian agencies, such as local community service agencies, public schools, and colleges are encouraged to participate in the training.

h. The number of hours of instruction and training will be determined locally, depending on need.

Section III
Uniforms and Awards

3–7. The ACS volunteer uniform

a. To identify volunteers easily with the ACS program, a distinctive uniform has been designed. The basic uniform consists of blazer, blouse, scarf, skirt, slacks, or dress for women. Men will wear the ACS blazer or safari shirt. Each installation will establish which combinations constitute the uniform to be awarded.

b. The uniform will be presented as an award (*e* below) on completion of 50 hours' service and orientation training. Additional items may be purchased by the individual volunteer on completion of volunteer training.

c. All volunteers must be in uniform with name tag while on duty.

d. To meet the uniform requirement, local installations will maintain a supply of cobbler aprons and safari shirts available for volunteers prior to awarding the basic uniform.

e. The following applies to wearing the uniform:

(1) Name tag will be worn on the right side of the outer uniform (AR 670–1, para 1–6*c*).

(2) Gold hour bar and year guard (including the authorized DA ACS pin) will be worn on the left collar of outer uniform. (See fig 3–1.)

(3) Shoes should be either dark or neutral and conservative in style.

(4) Jewelry should be inconspicuous.

(5) No patches, stripes, or chevrons will be fastened to the jacket other than the DA authorized ACS emblem.

(6) ACS brassards may be worn (AR 670–5, paras 14–26 and 14–30).

3–8. The ACS volunteer award program

a. General. In recognition of volunteer participation and achievements in the ACS program, commanders are encouraged to award volunteers the ACS pin, the ACS year guard, and ACS uniform. They may also present volunteers with special awards, such as the ACS hour bar and letters of recommendation, commendation, or appreciation for outstanding service. In addition, they should make use of Department of the Army Certificate of Appreciation for Patriotic Civilian Service for Exceptional or Outstanding Service in accordance with AR 672–20.

(1) Army volunteers may work with family service activities of the US Air Force (USAF), US Navy (USN), US Marine Corps (USMC), and US Coast Guard (USCG), or other uniformed service volunteer activities. Such volunteers can transfer these hours worked to ACS to apply for awards.

(2) Requests will be honored when USAF, USN, USMC, or USCG volunteers working in an ACS program want their hours credited and transferred to their own family service program. To insure that such volunteers receive credit for hours worked, the ACS center will give them a second copy of their records.

b. ACS pin. The ACS pin will be awarded to new active volunteers after completing 50 hours of service. Qualifying service will include the initial orientation. The pin will be worn on the left collar of the outer uniform.

c. ACS year guards. A chain with guard will be awarded as follows for the number of volunteer service years completed:

(1) One-year guard. Completion of any active 12-month commitment, including volunteer training and service.

(2) Second and successive year guards. Completion of additional consecutive 12-month periods of approved active service.

(3) Year guard is to be worn attached to ACS pin.

d. ACS hour bar. A gold hour bar will be awarded for 100 hours contributed to the ACS program. Further awards will be in increments of 250 hours when earned and approved. The hour bar will be worn on the right collar of the outer uniform, parallel with the ACS pin.

e. ACS uniform awards.

(1) The uniform will be awarded after the volunteer has completed 50 hours of actual service. The time will include hourly credit for any completed part of the volunteer corps training program. Replacement of uniform items should also be considered as awards.

(2) Initial award of the ACS uniform will be entered on the volunteer's record card.

(3) The ACS uniform is not an accountable item of issue and will become the property of the volunteer to whom it is awarded.

f. Certificates and letters. Certificates and letters of recommendation, commendation, or appreciation will be presented as appropriate. Letters should be presented through the chain of command.

Section IV
Volunteer Participation Recordkeeping

3–9. General

Daily time records and service records will be kept on all volunteer corps members. The volunteer supervisor is responsible for preparing and maintaining these records. DA Form 4713–R (Army Community Service Volunteer Daily Time Record) and DA Form 4162–R (Army Community Service Volunteer Service Record) will be used for this purpose. 3 DA Forms 4713–R and 4162–R will be reproduced locally on an 8- by 5-inch card. Copies for reproduction purposes are located at the back of this regulation.

3–10. Instructions for completing DA Form 4713–R

a. Recording. Credit hours earned will be entered on the daily time record for the appropriate day and month the volunteer worked. The record for hours worked will be the responsibility of each volunteer. Daily credits will be totaled monthly and entered on the record. Monthly figures will be totaled at the end of the calendar year and entered on the volunteer's permanent service record.

b. Optional recording procedure. Additional daily time records may be kept for each volunteer when local programs require recording the total number of volunteer hours by committee. Committee assignments will be shown on the reverse side of DA Form 4713–R.

c. Crediting hours of service.

(1) Credit will be given for each hour of volunteer service performed. Include hours spent in orientation, other ACS training activities, and round trip travel time from home to the ACS center. TDY at conferences or workshops will be credited at 24 hours per day.

(2) Volunteers performing on-call duties will be awarded 2 hours of credit for each 24 hours spent on call. This is in addition to the hours of volunteer work performed during regular tours of duty.

(3) Extra credits will be awarded and entered into the monthly total column of the daily time record for volunteers who serve in the following capacities:

(*a*) HQDA volunteer consultant and deputy volunteer consultant—20 hours a month.

(*b*) MACOM volunteer consultant—15 hours a month.

(*c*) Volunteer field consultant—10 hours a month.

(*d*) Volunteer supervisor—10 hours a month.

(*e*) Volunteer committee chairperson—5 hours a month.

(4) ACS volunteers who offer their services to the family services program of another uniformed service will receive hour-for-hour credit toward ACS awards for which they are eligible. When they return to an ACS program, appropriate totals will be entered in the annual hour section of DA Form 4162–R.

3–11. Instructions for completing DA Form 4162–R

a. The volunteer service record is used to enter information to assist the volunteer supervisor and the ACS officer in assigning individual volunteers. It is also to record individual volunteer service data to establish eligibility for ACS awards.

b. Additional information useful in making assignments may be entered in the Remarks section. No derogatory information may be entered on this form.

c. Although the form is maintained by the volunteer supervisor, volunteers will have access to their service records and be encouraged to keep them current.

3–12. Volunteer tracking and recordkeeping personnel file

a. A volunteer may request that a personnel file be kept for career development purposes (i.e., portfolios and resumes). This request is honored when the volunteer has—

(1) Completed 3 years with ACS, including chairing a committee.

(2) Served 500 hours with ACS.

(3) Served 1 year as a volunteer supervisor or assistant volunteer supervisor.

b. This file will be assembled with the cooperation of the volunteer and the ACS officer.

c. The file will be a total record of all volunteer service to include: training, positions held, work experience (paid or nonpaid, in or out of ACS, and awards received).

d. The volunteer may also request that letters of recommendation, commendation, appreciation, and evaluation of performance be included in his or her file. It is the responsibility of the ACS officer to insure that such requests be honored.

e. The file will be secured in the local ACS center.

f. Portfolios and resumes will be the responsibility of the volunteer.

g. On departure from the center, the file should be released to the volunteer after a review of it with the ACS officer. The file must be signed for by the volunteer. The file then becomes the property of the volunteer and his or her responsibility. Volunteer responsibility for the file would cease when it is presented for safekeeping and monitoring to the next ACS center where the volunteer will be assigned.

h. Volunteers may use any of the file material for employment outside of ACS.

i. If a volunteer does not remove the file from ACS, it will be retained for 1 year. During that time, the volunteer can request that the file be mailed to a receiving ACS officer at a specific center. Otherwise, the file may be destroyed.

j. When possible, the ACS officer at the gaining center should be notified of the volunteer's anticipated arrival so that contact may be made.

3–13. Disposition and transfer of records

a. On resignation or retirement, the original record will be given to the volunteer, and the word "Resigned" or "Retired" will be indicated across the face of the card.

b. In case of transfer, the original record will be given to the volunteer. A duplicate of this record will be furnished to the gaining ACS if requested.

c. In case of inactive service, the original record will be maintained for 2 full years following inactivity.

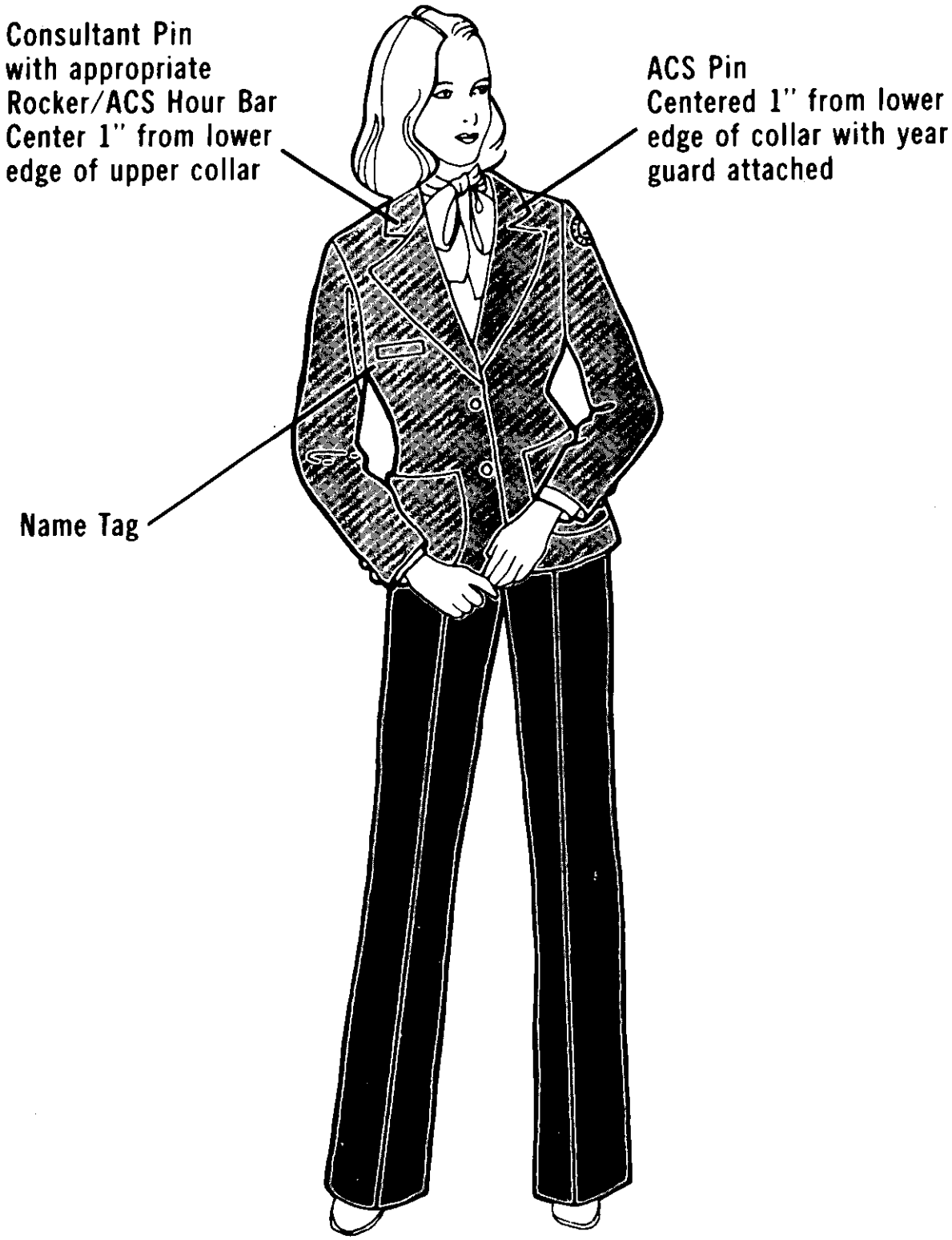


Figure 3–1. ACS volunteer uniform

Chapter 4
Consumer Affairs and Financial Assistance Program

Section I
General

4–1. Consumer affairs
This program focuses on improving service members' personal financial status and their abilities to perform as informed consumers.

4–2. Program objectives
a. Service members and their families are taught basic financial skills.

b. Financial assistance is available to service members as needed.

c. Specific information on local products and services is available to service members at all installations.

d. Military consumers are aware of consumer issues.

Section II
Program Components

4–3. Basic education
The services discussed in this section are designed to help service members obtain the basic financial skills necessary to develop a sound financial plan for themselves and their families. They are also designed to prevent soldiers from being distracted from their primary duties. Personal financial problems often detract from the readiness mission of the Army by promoting stress, time loss from training missions, and costing the system and the individual valuable dollars and time. They are also a primary cause of psychosomatic and stress-related illnesses, person abuse, substance abuse, susceptability to espionage, and a negative military image. Therefore, an initial consumer and financial affairs training program will be provided for all military service members. This initial program will be supplemented with refresher courses throughout the soldier's career. This training is referenced in AR350–1, chapter 4, and is referred to as "Soldier Money Management."

a. Inprocessing and basic education program. Inprocessing at a soldier's first duty station will include a block of instruction on Soldier Money Management. It is also highly encouraged that this block of instruction be made available to family members. Inprocessing for soldiers and family members being assigned to subsequent duty stations should include local consumer information, information regarding taxes, real estate laws, and other matters concerning that particular area or country. The financial education course for first permanent duty station service members should cover the following areas:

(1) *Banking and credit union services.* The military member will be given an overview of the services provided by financial institutions and their use. Training in the use of these institutions will include services offered from the automatic check deposit system to obtaining secured and unsecured bank loans and safety deposit boxes.

(2) *Budget development and recordkeeping.* The program will help service members learn how to plan for their expenses based on income and the need to plan for emergency expenses. It will also cover the importance of good personal and financial records and include information on methods of keeping these records.

(3) *Debt liquidation.* Military personnel will be taught the responsibilities and legal aspects of overextending their financial obligations. They will also be taught how to reduce debts and become financially solvent. Emphasis will be placed on the consequences of bad credit ratings in both the military and civilian environment. Other topics to be covered include the Soldiers and Sailors Relief Act, ways to work with companies to reduce installment payments, and credit card use.

(4) *Credit.* The military consumer will be briefed on both the use and abuse of credit. Specific areas covered will be the right to obtain credit regardless of sex, race, age, or national origin; credit cards and PX credit line system; cost of installment buying; and cost of loans, interest, and penalties.

(5) *Consumer rights and obligations.* Military consumers will be informed of their rights to see their records; review contracts, cancel contracts, and return goods; be informed; and have input in areas of consumer concern. These concerns include the consumer's right to—

(*a*) Safe products, services, and environment.

(*b*) Be informed of the products and services available.

(*c*) Have input into the system to improve the way things are being done.

(*d*) The resolving of complaints.

(6) *Insurance.* Information on different costs and types of insurance will be discussed.

(7) *Local information.* Consumer laws differ from country to country, State to State, and city to city. Because of these differences, a mandatory inprocessing course will be developed by each installation. Local laws and regulations regarding housing, taxes, schools, and financing are examples of areas to be covered.

b. Consumer handbook. A consumer handbook will be distributed to service members. It should contain the following information:

(1) Services available to military personnel at installations (PX, commissary, health, housing referral, and legal services).

(2) Copies of sample letters and forms used in resolving complaints.

(3) Comparison shopping.

(4) Returning defective merchandise.

(5) Warranties and guarantees.

(6) Insurance.

(7) Consumer publications.

(8) Other relevant consumer agencies.

(9) Use of other DA and civilian suggestion systems.

(10) An outline of basic local laws and restrictions affecting military consumers. These may include real estate, insurance, banking, taxing, and licensing requirements.

4–4. Financial assistance services

Financial services offered are designed to help service members improve their credit reliability and reputation, to reduce levels of indebtedness, and to make their money work for them.

a. Debt liquidation assistance. The commander has the responsibility (AR 600–15) to assist Army members in meeting their financial obligations by helping them to consolidate and liquidate debts. These services should be designed to involve clients encouraging them to work with their own creditors to gain a stable, manageable, financial position. Debt liquidation services are particularly well suited for short term debts. These services may be provided in conjunction with reputable programs sponsored by public or private agencies.

b. Budget development and financial planning. These services provide guidance and information on the development of budgets and achievement of future financial stability and growth.

c. Records. Records of individuals or families enrolled in budget development and debt liquidation services will be kept in accordance with AR 340–21. These records will be used to advise service members and their family members regarding the creation of sound economic plans. The records also serve to prevent an increase in financial problems and to aid in their resolution. Records will—

(1) Be filed alphabetically in individual folders by last name of individual.

(2) Contain all listings of financial resources and liabilities, proposed budgets, schedule of payment, inventories of important records and papers, and all similar documents.

(3) Be available to the ACS officer, financial planning and consumer affairs coordinator, and other authorized ACS staff. No other person will have access to the files.

4–5. Consumer advocacy program

Every effort will be made to design policies to serve the consumers and to provide them with the information needed to make educated decisions. Specific attention will be given to having an information and referral system for complaints regarding civilian and military services and products. The system should include the consumer's right to have the consumer affairs coordinator intercede on his or her behalf when all other recourse has failed.

4–6. Complaint resolution system

a. All complaints received by the consumer affairs personnel will be logged in a central file or log book. Information on the date, nature, location, and parties involved in the complaint will be recorded on DA Form 5184–R (Consumer Complaint). DA Form 5184–R will be reproduced locally on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation. The consumer will then be referred to the installation official who is responsible for the area in which the complaint occurred. If the complaint is against a civilian agency, the consumer will be referred to the appropriate civilian (or host nation) consumer assistance agency. The consumers will keep the consumer affairs office informed on the status of the complaint including if and how it is eventually resolved. If the agency fails to resolve the issue or give the consumer a valid reason why it is not possible, the consumer affairs coordinator will intercede. If the problem is not solved at the installation, the complaint will be referred to the MACOM consumer affairs officer. If the MACOM officer cannot resolve the problem, it will be referred to HQDA. The HQDA coordinator will monitor the type and number of the complaints received to determine whether Army-wide policy changes need to be recommended.

b. Documenting cases in this program and the impact of individual complaints on the total system will bolster feedback from individual participants.

c. Civilian establishments that employ unfair business practices adversely affecting the health, welfare, or morale of a command may be placed off limits to Armed Forces personnel (AR 190–24).

4–7. Public information and outreach program

A continuing effort will be made to educate consumers on budgeting, check writing, financial planning, best buys, open dating and unit pricing. This effort can be accomplished through commanders' calls, telephone hotlines, installation newspapers, books, pamphlets, fact sheets, films, and Armed Forces Radio and Television Service (AFRTS) program overseas. Communications media available at each installation should be coordinated to provide an effective awareness program for the public. Information on the consumers affairs program

services available at each installation will be made a part of welcome packets given to new arrivals.

4–8. Emergency funds available to service members through Army Emergency Relief and the American Red Cross

Emergency funds may be available to service members through Army Emergency Relief (AER) (AR 930–4) and the American Red Cross (ARC) (AR 930–5). These organizations and many national, State, and local veterans organizations provide supplemental benefits for retirees, widows, and their family members. Services of these agencies can be used to supplement ACS programs. Veterans organizations include the American Legion, the Disabled American Veterans, Veterans' Administration, and the Veterans of Foreign Wars.

Chapter 5
Relocation Program

Section I
Program Overview and Responsibilities

5–1. Military transfers

a. This program provides information, guidance, and assistance to support unit deployments, service members and their families in moving from one military community to another. It also covers settling into a new community.

b. ACS centers will not duplicate or assume responsibility for services available elsewhere on-post, such as housing referral activities. Continuity of service delivery, however, is important and can be improved through interagency coordination.

c. Inprocessing through ACS is required for all newly arrived personnel. This insures early contact with units and individuals relocating.

5–2. The ACS directory

a. HQDA will prepare and distribute an ACS directory. The directory will contain a list of the complete mailing address, building number, autovon and commercial telephone numbers of ACS centers worldwide.

b. ACS centers will report corrections and changes in the directory to their MACOMs for forwarding to HQDA(DAAG–PSC), ALEX VA 22331.

c. Each ACS center will send installation fact sheets and welcome packets annually (para 5–4) to HQDA and to all other ACS addresses in the directory.

Section II
Program Components

5–3. Premove assistance

a. ACS will assist units and installation personnel with premove briefings for service members and their families. These briefings can minimize personal and financial stress associated with a move.

b. Each year, ACS will prepare a DA Form 4720–R (Army Community Service Installation Fact Sheet) on local conditions, resources, and other special interest items. The updated form will be included in ACS welcome packets. The ACS officer will distribute a copy of the welcome packet to all ACS centers worldwide. This will enable relocating personnel to learn about their new installation before they leave their old one. DA Form 4720–R will be reproduced locally on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.

c. ACS will assist in conducting training workshops for persons designated as sponsors by AR 612–10. Training will include—

(1) Locating a temporary or permanent rental unit in coordination with the housing referral office.

(2) Assisting spouse in finding employment in either a temporary situation or a career opportunity through the civilian personnel office (CPO).

d. ACS training workshops will provide information on the following:

(1) Educational facilities both in the military and civilian communities.

(2) Military and civilian medical and dental care facilities.

(3) Community services and facilities both on-post and in the local community.

(4) Host nation cultures, customs, and lifestyles.

(5) Local vehicle registration, safety inspection, emission standards, and insurance requirements, and when available, typical insurance rates.

(6) Local firearms laws and restrictions.

(7) Problems that could arise when shipping pets to an oversea command, e.g., quarantine periods.

e. For families going overseas, whether individually or as part of a unit deployment, ACS will assist in conducting workshops about preparing for assignments abroad from a personal perspective. Topics covered will include developing realistic expectations, coping with interrupted activities and relationships, and sharpening communication skills.

f. To assist families entering CONUS, ACS will assist in conducting workshops on stress that adults and children experience on their return to CONUS. The workshops will demonstrate ways to better readjust to a home assignment.

5–4. Postmove assistance

a. During inprocessing, ACS will identify service members with families and perform the following:

(1) Distribute welcome packets to include ACS fact sheets, recreational, and other resource information.

(2) Maintain welcome packets in the ACS resource library (para 2–4). The library should also include information about the local military and civilian communities.

(3) Provide military community members with information on other installations worldwide.

(4) Review all information in the ACS resource library at least semiannually.

(5) Publicize the library at least semiannually with special attention to trainees and students.

b. Conduct or participate in orientation briefings according to AR 612–10.

c. Administer the lending closet to assist service members in establishing a new household. The temporary loan of household items need not be restricted to personnel who are in the process of relocating. Priority for the use of these services will be determined locally. Standard supply procedures apply in administering the lending closet.

5–5. Command planning for family member assistance during emergencies

a. Planning and preparation for emergencies relating to care of Army families must be a continuing consideration. Every possible means will be used to insure that the well-being, morale, and welfare of Army families is maintained. Families can suffer loss through fire, flood, or other natural disaster. Military operational requirements can also cause a disruptive and adverse impact on the morale and well-being of Army families. ACS should serve as the hub for assistance.

b. A service member can suddenly be ordered to an unaccompanied permanent change of station (PCS) tour. If the sponsor is unable to resolve personal problems at this time, a plan to alleviate family difficulties must be placed into effect. Problems should be anticipated in such areas as financial support, housing, transportation, child care, relocation, legal affairs, medical care and treatment, and personal adjustment.

c. Use of such a plan will give assurance of maximum Army assistance to family members and reduce adverse morale. This plan is based on the following considerations:

(1) PCS orders for military personnel may arrive too late to start or complete personal and family care planning.

(2) The majority of affected family members may reside in a civilian community. Some of these family members may not be entitled to transportation or movement of household goods (grades E4 and below with less than 2 years service).

(3) All personal and financial actions to provide care and support for family members are being initiated and processed by commanders of individuals or deployed units.

(4) Necessary support for preparation of allotments and other administrative actions is available during transit status of military personnel.

(5) Necessary support for legal services, including wills and powers of attorney, is available.

(6) Maximum effort to insure proper support of family members is made by commanders of all military personnel.

d. Planned actions for departure date of sponsor/unit D–Day to D–Day+3.

(1) Establish a central agency to support family members with information and assistance.

(2) Inform all family members by the quickest way of the sponsor's departure. Let them know of postal arrangements, the whereabouts of a central agency for immediate and emergency needs, and plans for family orientations to assist in personal planning.

(3) Designate officer and unit sponsorship for specified segments of the family population.

(4) Insure the appropriate security, storage, or necessary shipment of personal property of deployed personnel who have no families.

e. Planned actions for D–Day+4 to D–Day+120.

(1) Establish coordination with AER and the ARC to insure rapid response to emergency financial needs.

(2) Insure continued processing of personnel actions affecting financial support of family members.

(3) Insure availability of guidance and assistance in resolving problems of indebtedness.

(4) Urge all relocating family members to seek housing near a military installation in order to take advantage of medical care, commissary, PX, and other facilities.

(5) Establish priorities for movement among family members residing on-post and off-post. Commanders may allow families of departed service members to retain on-post housing on a case-by-case basis. They can also provide excess housing in accordance with AR 210–50, chapter 3.

(6) Assess availability of local facilities to move, pack, and crate household goods.

(7) Establish contacts with installation housing referral office to assist in locating housing in CONUS for relocating family members.

(8) Encourage families living off-post in CONUS to retain current housing unit until return of sponsor, when circumstances permit.

(9) Consider problems confronting family members of soldiers who are not authorized Government transportation of family members and household goods.

(10) Provide assistance for the disposition or transportation of automobiles and trailers.

(11) Maintain or increase post capability in the following areas:

(*a*) Child care (day nurseries, 24-hour care, and special care for exceptional family members).

(*b*) Local transportation of family members (car pools and other volunteer means of transportation).

(*c*) Medical care and handling of personal adjustment problems.

(*d*) Youth activities and supervision to reduce incidence of delinquency.

(*e*) Casualty assistance.

(*f*) Recreational activities.

(*g*) Volunteer assistance services to include all areas of potential need.

(*h*) Emergency assistance.

f. Planned actions from D—Day+121 for an indefinite period.

(1) Resolution of special problem areas outlined in *e* above.

(2) Maintain personal sponsorship and provide centralized assistance and contacts for affected family members residing in the civilian communities.

5–6. Services to waiting families

a. ACS will serve as a two-way communication, information, and mutual support program for military families along the chain of command. This program can help families during unaccompanied tours, extended TDY, field training exercises, and mobilization. The program will also—

(1) Provide commanders with civilian and military resources to assist them in their efforts to alleviate stressful situations in families.

(2) Link military and civilian services and opportunities with families in need.

(3) Reinforce concepts of self-help and mutual aid.

(4) Coordinate activities to teach families how to take advantage of services and resources.

b. A basic waiting families program will include the following:

(1) Assignment of military sponsors to families occupying Government quarters during a service member's absence. This will insure that difficulties experienced by the family are resolved quickly. Also the family will be kept informed of any changes in their housing and military status.

(2) Predeparture briefings regarding stress factors and practical arrangements of family separation or relocation.

(3) Family member assistance handbooks for spouses and other family members to supplement predeparture briefings. This handbook will contain a briefing introduction by the commanding officer of the unit. It will include information, such as—

(*a*) A directory of important phone numbers.

(*b*) A brief description of the various services and sources of assistance available through the Army or the civilian community.

(*c*) A discussion of potential problems and suggestions for dealing with them.

(*d*) A predeparture checklist.

(4) Emergency services, such as—

(*a*) Food.

(*b*) Clothing.

(*c*) Transportation.

(*d*) AER and ARC.

(5) Child support services.

(6) Social and recreation activities.

(7) Workshops, such as:

(*a*) Parenting.

(*b*) Nutrition.

(*c*) Financial management.

(*d*) Employment.

(*e*) Safety precautions.

(*f*) Separation and reunion.

(*g*) Stress management.

5–7. Services to foreign-born spouses

a. Each ACS will insure that families with foreign-born spouses receive extensive support and services to include courses in English as a second language. The ACS should also assist the American spouse in coping with the stress of a bicultural marriage in the United States.

b. A basic program for foreign-born spouses and their families will include—

(1) Mutual language and cultural training for both spouses. It should take place at the time of marriage, if feasible.

(2) Special courses for sponsors and other service providers to explore methods of meeting the needs of these individuals and families.

(3) Informational materials such as fliers, handbooks, and audiovisual programs designed to help foreign-born spouses better understand American culture. This understanding could help them cope more effectively with adjustment.

(4) Short term crisis intervention for families where there is a foreign-born spouse. Areas covered should be premarriage guidance, marital conflict, pressures, and problems faced by both spouses and their children. It would include meeting personal needs in a foreign culture, coping with Army life, and societal expectations in the United States.

(5) ACS assistance to commands with sponsorship programs for newly arrived, foreign-born spouses who receive support. If possible, assistance should be sought from other foreign-born spouses.

(6) Programs to help civilian agencies aiding service members and families by providing them with information and training on the special needs of families with foreign-born spouses.

(7) Developing and maintaining a list of interpreters for various nationalities that will assist families in communicating their needs.

(8) Contacting various international organizations to provide supportive services, such as language and culture.

5–8. Educational and employment services to family members

a. ACS will insure that family members receive complete information and assistance when seeking services for educational planning, paid employment positions, or volunteer opportunities.

b. ACS will not assume responsibility for services

available elsewhere. It will coordinate, complement and, when necessary, expand already existing military and civilian services. Expansion could lead to establishing a central office for such services as direct assistance relating to local educational and employment opportunities.

c. A basic program will include—

(1) Maintaining an awareness of the current employment market and volunteer needs and opportunities in the area.

(2) Having information files on military and civilian educational opportunities, such as scholarship and financial assistance programs.

(3) Keeping information files on civilian employment openings for company training and reentry programs, and volunteer opportunities and agencies. ACS should outreach to civilian agencies, encouraging them to hire family members by registering position vacancies with ACS. Services related to Federal employment will be coordinated with the CPO.

(4) Providing assistance in preparing family members to identify and develop their marketable skills.

(5) Giving positive support and encouragement to family members seeking self-development opportunities.

(6) Having a library of resource materials, to include books, brochures, pamphlets, magazines, and newsletters on a broad range of educational and occupational areas.

(7) Sponsoring or coordinating workshops on topics such as personal goal-setting, time and stress management, coping with a mobile lifestyle, resumes, and job interviews.

(8) Providing a liaison for the military member to local resources such as temporary employment services, State employment centers, and the post education center.

(9) Providing a centralized job bank for teenage family members for after school, weekend, and summer employment opportunities.

*Chapter 6
Information, Referral, and Followup Program

Section I
Program Overview and Responsibilities

6–1. Program concept

a. Service members and their families must have ready access to information that will assist them in solving their social and economic problems. They should also have information to help them meet their basic needs, and improve the quality of their lives.

b. Direct and supportive assistance will be provided according to local needs and available resources.

c. Many activities on an installation provide information and referral services. The ACS center will be the primary resource agency for providing these services. Consideration should be given to the consolidation of installation information and referral activities when duplication in services exists. Coordination of service delivery with other community agencies and other information and referral-type services is essential.

6–2. Program objectives

The objectives of information and referral are to—

a. Provide commanders and service members and their families with information regarding military and civilian community resources.

b. Link service members and their families requesting assistance with the appropriate agency or service.

c. Identify problems in service delivery system and consider long-range community planning.

Section II
Program Components

6–3. Resource information

a. The program must maintain an accurate, up-to-date directory on available resources.

b. The resource directory may be in the form of double card files or an automated system. It will have the following components:

(1) An alphabetical listing by name of all public, private, and voluntary agencies providing essential services. The listing should be cross-referenced.

(2) An alphabetical listing of each agency service under the classification system codes (para 6–4).

(3) An area listing of agencies in commonly accepted geographical subdivisions.

c. Each agency directory will include the following descriptive material:

(1) Name, address, and telephone number.
(2) Director.
(3) Contact person.
(4) Business telephone.
(5) Emergency telephone.
(6) Afterhours telephone.
(7) Business hours.
(8) Service hours (days/hours).
(9) Area served.
(10) Branch offices, addresses, and telephone numbers.
(11) Type of agency.
(12) Service accessibility.
(13) Fees for service.
(14) Eligibility requirements.
(15) Intake process.
(16) Services provided.

d. The resource directory will be updated semiannually.

e. The resource directory will be used in developing and publishing the following:

(1) A leaders' referral guide to human services for commanders and their staffs.
(2) Emergency data cards for service members.
(3) A directory of human services for installation agencies.

6–4. Classification system

a. The program will use a classification system common to all information and referral services throughout the State or host nation. The system will standardize definitions to facilitate retrieval of service information. This will increase the reliability of planning data generated by service deliverers. The system will also make comparison evaluation processes consistent, reliable, and improve networking.

b. The classification system will vary according to the complexity, size, and nature of the community being served. However, the basic outline or related service definitions will not change.

6–5. Methods used to provide adequate service

a. General. Adequate provisions of service will consist of sound practices that result in linking service members and their families to needed services.

b. Interviewing and assessment. Interviewing will be limited to obtaining sufficient information to make an assessment to provide accurate information or referral.

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The assessment will consist of an accurate understanding of the problem through identification by the service member and the staff.

c. Information-giving. Information obtained will be accurate and pertinent to an assessment of the problem. If the service member seems able to follow through without assistance, information will be gathered without further staff participation. In this case, provisions will be made for callback.

d. Referral. Referral will be made when assessment of the problem indicates that further assistance is needed for linkage to required services. Referral will include active participation of the staff in recommending the service member to the needed service.

e. Followup.

(1) Followup will consist of contacting the referral agency and the service member to find out whether or not contact has been made and the service is being provided. Followup will be recorded on DA Form 5185–R (Agency Followup) for all referral cases. The staff will determine the information-giving cases that require followup. DA Form 5185–R will be reproduced locally on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.

(2) If linkage has not occurred, the staff will reassess the service member's situation to determine if other appropriate action can be undertaken.

f. Advocacy. The program will offer advocacy on behalf of a service member or group of service members. Advocacy will occur when needed services are not being provided for by an agency within the community's service delivery system.

6–6. Data collection

a. The data collection system will be developed to meet the needs of service members and the community as a whole. This system will include information for community planning of essential human service. Data collection can demonstrate inadequacies of present services, overlaps, gaps, duplications, and unmet needs. The system will provide information for evaluation of the service itself. Data collection procedures will follow acceptable principles of confidentiality. The right of the service member to withhold information not directly relevant to the resolution of problems will be protected in data collection.

b. Three sets of data (client, performance, and problem or service) will be collected. Client data refers to information about specific service member characteristics such as age, sex, rank, and length of service. Performance data provides a means of capturing information on the workload, volume, and results of the information and referral program. Problem or service data provides information useful for assessing not only the types of problems encountered by clients but also gaps in a community's service system. DA Form 5186–R (Client Inquiry and Disposition Data) will be used for recording client contract. DA Form 5186–R will be reproduced locally on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.

6–7. Training

a. Training will be provided to paid and nonpaid staff to insure adequate delivery of information and referral services.

b. Preservice training will consist of skills training in the areas of interviewing techniques and attitudes, listening skills, communications, and proper telephone usage. It will include assessment techniques, information and referral procedures, followup, data recording, maintenance of records, and use of resource files. Training and techniques of limited short term crisis intervention for handling calls from the lonely, suicidal, despondent, and angry inquirer will also be provided.

c. On-the-job training will consist of a program of increasing levels of involvement in handling inquiries. This will begin with observation and end with full responsibility for handling inquiries.

d. Inservice training will continue on a regular basis and should include updating the staff's understanding and knowledge of appropriate topics. These topics will include the operation of human service systems (legal, health, aging, welfare, governmental, and education). Inservice training should also address techniques that assist workers in maintaining personal perspectives.

Chapter 7
Army Family Advocacy Program

Section I
General

7–1. Concept of the Army Family Advocacy Program (AFAP)

This is a specialized program to prevent child or spouse maltreatment and its attendant problems. The program also identifies, treats, and rehabilitates the maltreater as well as treating the maltreated individual. The philosophy of the program is to provide the services Army families need to maintain a sound quality of life. Continuing episodes of abuse could possibly lead to criminal or administrative actions. All available assistance must be provided to alleviate underlying causes of child or spouse maltreatment.

7–2. Family advocacy objectives

The objectives of the program are shown below.

a. Develop programs or activities that contribute to a healthy family life. This can lead to restoring to a healthy state those families suffering from child abuse or neglect or spouse abuse.

b. Insure command and staff personnel are aware of their responsibilities for preventing child or spouse maltreatment. Responsibilities include identifying, reporting, treating, and following up with families involved in abuse.

c. Identify, report, manage, and followup cases of child or spouse maltreatment among families eligible to receive treatment in medical treatment facilities (MTF). Comprehensive followup will—

(1) Assist family members in recognizing causes of child and spouse abuse and improve family functioning.

(2) Provide for the protection and treatment of maltreated family members.

(3) Cooperate with responsible civil authorities to address the problems of child or spouse maltreatment; report cases according to local, State, and host nation guidelines. If guidelines do not exist, policies and procedures in this chapter will be followed in implementing this program.

(4) Assure that families suffering from child or spouse maltreatment are advised of how to obtain medical, legal, law enforcement, and counseling help.

d. Prevent and control child or spouse maltreatment by—

(1) Educating and training personnel.

(2) Developing an awareness of the causes and consequences of child and spouse abuse.

(3) Stressing commandwide programs of prevention and treatment.

(4) Coordinating available services, both civilian and military.

(5) Making specific efforts to serve military families living off-post.

e. Provide and support health promotion programs such as parenting, expectant parents, child growth and development classes, family living classes, and family enrichment. These programs assist families to attain better health.

7–3. Responsibilities for the AFAP

Overall responsibility for the AFAP is assigned to the Chief, ACS. The ACS and the MTF are to work cooperatively to provide prevention, education, treatment, and support services. ACS is responsible for prevention, community education, liaison with community and military services and support services such as temporary shelter and short term crisis intervention. The MTF is responsible for medical and clinical treatment services. A close working relationship and clear understanding of roles and responsibilities must exist between ACS and MTF.

a. Installation commander. The commander will—

(1) Establish programs for the prevention of child or spouse maltreatment (para 7–6).

(2) Develop services for children and their families (para 7–7).

(3) Establish programs for battered spouses where civilian programs are not readily available or accessible (para 7–8).

(4) Install mandatory counseling programs for batterers (para 7–9).

(5) Appoint a family advocacy program coordinator (FAPC) to monitor and provide staff supervision. The coordinator will serve on the installation FACMT (*g* below).

(6) Review reports and minutes of the FACMT, AFAP activities, and consult directly with the FAPC to keep informed of AFAP actions.

b. Unit commanders and supervisors (military or civilian). The commander will—

(1) Be familiar with rehabilitative procedures and disciplinary policies relating to child or spouse maltreatment.

(2) Be responsible for referring service members involved in child or spouse abuse to the FACMT POC.

(3) Insure that sponsors receive counseling and referral assistance as recommended by the FACMT. Permit schedules for sponsors to attend classes that promote better health.

(4) Be aware of the variety of actions that can be taken to handle reports of spouse abuse. Among these is

restricting the abusive sponsor to the installation (c(6) below). The unit commander will support the program by making clear that the abusive behavior must stop at the risk of serious consequences. He or she must mandate treatment for the abusive sponsor. Emphasis should be placed on consequences for unacceptable behavior.

(5) Based on FACMT recommendations, start personnel actions to flag service members while sponsors and families are engaged in the counseling process if PCS or other actions would prove detrimental to progress in the case. (See AR 614–200, chap 3, sec II.)

(6) Initiate personnel actions to separate service members when the commander in consultation with the FACMT determines that further rehabilitation is not practical. For officer separation, see AR 635–100; for enlisted personnel, see AR 635–200. Case-by-case circumstances must be reviewed (para 7–20).

(7) Serve as a member of the FACMT as necessary.

c. Installation SJA. The SJA will provide legal advice to the command and AFAP personnel. The SJA will also provide guidance for—

(1) The FACMT to insure that the team's activities and staff procedures conform to civil and military law. The SJA will also function as a member of the FACMT.

(2) Medical or other personnel in reporting incidents of child or spouse maltreatment to military and/or civil authorities.

(3) The authority that State officials, oversea commands, and host nation authorities may exercise over military personnel and family members who are residing both on and off a Federal installation. The SJA should advise the commander and AFAP personnel on local legal constraints and suggested courses of action in the following areas:

(*a*) Compulsory medical examination and treatment for children suspected of being maltreated.

(*b*) Removal of child from the home.

(*c*) Placement of child in a foster home or institution.

(*d*) Hospitalization of child for medical and protective service only.

(*e*) Involuntary protective police or medical hold on the minor child in child abuse and neglect cases.

(4) The authority that foreign officials in oversea areas may exercise over the actions of FACMT personnel.

(5) Battered military members and battered spouses regarding legal rights to housing and financial support. Included will be jurisdictional issues that may arise with the criminal justice system. The SJA will also advise the battered spouse of procedures for civil action that may be taken to obtain an enforceable separation, divorce, custody of children, and any other appropriate civil actions.

(6) Guidance to the unit commander in kinds of actions he or she may legally take in handling spouse abuse. Legal steps could include an order directing the abuser to move back on-post for a period of time, restriction to the post, and mandated attendance in a treatment program. More serious actions might be preferral of charges if the perpetrator is subject to the Uniform Code of Military Justice (UCMJ) (*b*(4)above).

d. Installation PM. The PM will—

(1) Coordinate with civilian law enforcement agencies in regard to handling child or spouse maltreatment.

(2) Promptly investigate cases of suspected abuse according to AR 190–30 and AR 195–2. He or she will coordinate these actions closely with the FACMT and the FAPC.

(3) Establish an SOP that outlines ways to deal with child or spouse maltreatment. Law enforcement personnel should be particularly aware of actions that would prevent further abuse. Such actions include apprehending the abuser, helping the victim obtain medical treatment, and informing both parties of available services.

(4) Conduct crisis intervention training for all law enforcement personnel. Training would cover the physical and emotional trauma associated with child or spouse maltreatment and proper management procedures.

(5) Forward all reported incidents of child or spouse maltreatment to the FACMT (para 7–5).

(6) Function as a member of the FACMT.

e. Installation PAO. The PAO will—

(1) Conduct media campaigns to increase community awareness of the problems of child or spouse maltreatment and the availability of resources (medical, legal, and law enforcement assistance and counseling).

(2) Monitor the release of information to the media regarding child and spouse abuse.

(3) Provide coverage of well-adjusted families and the importance of family communication.

(4) Participate in the AFAP.

f. Installation chaplain. The chaplain will—

(1) Provide an environment of pastoral concern to those families evaluated by the FACMT or FAPC as being dysfunctional. Continue support to them through pastoral visitation and counseling upon request or as referred by the FAPC.

(2) Function as a member of the FACMT.

(3) Assist in promoting installation activities, programs, and facilities to foster and improve the coping ability of families. Activities should include community education and awareness.

(4) Offer supportive services to the victim and assure that referral procedures are followed to provide available support services.

g. Installation FAPC. The installation FAPC will be

appointed by the installation commander. Appointees should be a social services professional (MOS 68R or GS 185 or equivalent series). They must have a range of administrative, management, and direct service experience and be able to deal with the complex issues associated with child and spouse abuse. The FAPC will—

(1) Monitor and provide staff supervision of the AFAP.

(2) Develop an SOP that outlines ACS's responsibilities and processes for providing an AFAP.

(3) Function as a member of the FACMT.

(4) Serve on the HR Council.

(5) Assess the special needs of military families residing on the installation and in the surrounding community.

(6) Identify deficiencies in services provided for the physical and emotional development of family members with particular emphasis on programs dealing with child or spouse maltreatment.

(7) Plan and coordinate Army family advocacy services specified in this regulation that are provided to eligible families.

(8) Work with the installation commander to insure programs for victims and perpetrators of child or spouse maltreatment are established (*a* above). Programs will include prevention services (para 7–6); services for children and families (para 7–7); and programs for battered spouses (para 7–8).

(9) Assure that support services such as temporary shelter and short- term crises intervention are available and accessible (para 7–8).

(10) Develop and publicize procedures for reporting all incidents of child abuse and assist personnel in reporting these incidents.

(11) Coordinate with the medical facility commander and the PM or security officer to insure that all reported incidents of child or spouse maltreatment receive immediate action, including treatment and followup services.

(12) Work closely with the PM to insure that identification, referral, and reporting procedures are followed (*d* above).

(13) Develop, with the medical commander and the PAO, a postwide prevention and education program. Such a program would—

(*a*) Inform all personnel about the seriousness of child and spouse abuse, to include the causes, effects, and remedies. Publicizing this information could broaden the base of potential identifiers of such abuse and insure public awareness of available services.

(*b*) Stress the need for a widespread willingness among personnel to report incidents of abuse.

(*c*) Emphasize the importance of total community involvement in the installation AFAP.

(*d*) Coordinate with the PAO to publicize available services (*e* above).

(14) Set up procedure for liaison and referral with local military and civilian health and human service agencies capable of assisting victims and perpetrators of child or spouse maltreatment. Have a listing of existing services, key contact persons, emergency and regular referral procedures, and eligibility requirements.

(15) Notify unit commanders of the disposition of child or spouse maltreatment cases and potential problems in assignments and responsibilities. Give the expected length of time in treatment, prognosis, duty limitations, and ways the commander can cooperate in the program.

(16) Train all ACS and other staff working with the AFAP in the need and assurance for confidentiality procedures. (See AR 340–21 and Systems Notice AO917.10, DASG, Family Advocacy Case Management Files.)

h. Alcohol and Drug Abuse Prevention and Control Program (ADAPCP). This program will—

(1) Provide counseling referral services to individuals whose alcohol or drug abuse may play a part in child or spouse maltreatment (AR 600–85).

(2) Serve as a member of the FACMT as necessary (para 7–4).

(3) At intake, inquire about the existence of spouse and child abuse.

i. The MTF commander. The MTF commander will—

(1) On direction of the installation commander, appoint and supervise a multidisciplinary FACMT (para 7–4).

(2) Assure that the chief of social work services coordinates the MTF family advocacy services to include child or spouse maltreatment intervention and clinical treatment services.

(3) Establish procedures for the medical identificaton and evaluation of suspected child abuse cases. Procedures should address the following:

(*a*) Possibility of child abuse when injury occurs without adequate explanation for the degree of injury sustained. This is emphasized when the story of the accident is not logical, or when there is a change in, or conflicting stories. In treating children, the medical facility should look for multiple fractures during the first 3 years of life, multiple injuries and bruises; recurrent injuries such as burns, severe trauma, skull fractures, or subdural hematoma of questionable cause. (A child declared dead on arrival should arouse suspicion of possible abuse.)

(*b*) Detection by dental services for possibility of child abuse when facial abrasions, a broken jaw, cheek bones or teeth, or lacerations in the mouth or tongue are present.

(*c*) Neglect in unexplained failure to thrive or in

an advanced untreated disease, or when a young child is left unattended for inappropriate periods of time or in inappropriate circumstances.

(*d*) Clinical evaluation of children and their families as soon as possible when child abuse is first suspected. Have the physician or nurse screen medical records of all family members for indications of previous abuse; arrange for medical evaluation by a pediatrician, and check central registry data to ascertain the existence of previous child abuse.

(*e*) Provision of prompt medical care and, if required, protection for the victim when a suspected case is brought to the medical facility.

(*f*) Collection of evidence of child abuse through documentation. All cases will be carefully recorded by the attending physician. A description of the child's general appearance and the location of bruises, contusions, fractures, and other injuries will be included. A detailed account of how injuries were reported to have occurred will be obtained from the person who brings the child to the MTF. This information will be recorded on appropriate medical forms and filed in the FACMT file (para 7–13). Other information should include photographs of the injuries, laboratory data, X-rays, and consultation reports as indicated.

(4) Establish procedures for the management of suspected child abuse cases. Procedures should cover areas discussed below.

(*a*) Admission of a child for further evaluation and treatment if it is determined or suspected that the child needs medical care or protection. When advising admission to the parent, the physician should stress the aspects of the case necessitating hospitalization. The chairperson of the FACMT will be notified and will determine the need to notify the FAPC, installation commander, SJA, and civilian authorities.

(*b*) Arrangements for admission to an appropriate military or civilian hospital if the medical facility does not have inpatient capability. The chairperson of the FACMT will be notified before the transfer unless urgency dictates otherwise. He or she will determine the need to notify the FAPC, installation commander, SJA, and civilian authorities.

(*c*) Notification of the chairperson of the FACMT if the parent or guardian refuses the admission or is unavailable. The SJA will also be contacted for assistance and guidance (*c* above). In no event should the life of the child be endangered by withholding emergency treatment or hospitalization.

(*d*) Consultation for the child in all available specialties. Such services include pediatrics, social work, orthopedics, neurology, psychiatry, pathology, radiology, psychology, and nursing.

(*e*) Clearance from the chairperson of the FACMT before the child is discharged from the hospital. If the parents want to remove the child from the hospital against medical advice, the attending physician will notify the chairperson of the FACMT and then obtain advice from the SJA.

(5) Establish a protocol for the identification, medical, and dental management of spouse abuse. This should include the following areas:

(*a*) Initial treatment and followup. Including inpatient and outpatient medical care for physical injuries sustained by victims of spouse abuse.

(*b*) Begin a process of active identification to reduce the incidents of further violence; and help the victim become aware of the seriousness of the situation and of existing resources and support. If a description of an accident is inconsistent with the injury sustained or when there are multiple injuries or injuries on the face, neck, chest, breasts, or abdomen with no reasonable explanation, spouse abuse should be considered. The victim should be referred to available services. Dental personnel should be aware of lacerations in the mouth and tongue, facial abrasions, or broken teeth, jaw, or cheekbones. The range of battered women's symptoms include anxiety or depression, suicidal behavior, marital problems, alcohol and drug abuse, and pregnancy or miscarriage.

(*c*) Separate the family members when spouse abuse is reported or suspected. Ask specific questions about the violent incident; what happened prior to, during, and after the episode. Offer the victim the opportunity to have a picture taken in order to document visible injuries for further court purposes.

(*d*) Provide counseling services for the victim and the batterer. The needs of each are different and each require the use of specific techniques and support services.

(*e*) Refer maltreated spouses to the FAPC who can explain available support services and coordinate the range of services needed such as job training, peer group counseling, and legal assistance.

(*f*) Consult with the SJA on the legal aspects of intervention in, and management of, spouse abuse cases.

(*g*) Coordinate with local civilian agencies on cases of spouse abuse under guidelines provided by the SJA.

(6) Establish an education program in coordination with the AFAP coordinator and the MTF POC to train FACMT members in the identification and management of child or spouse maltreatment.

(7) Insure that needed medical followup care or assistance is provided to the victims and perpetrators of child abuse.

(8) Make sure that proper medical steps are taken in cases of sudden or unexplained deaths that may be related to abuse.

(9) Provide assistance when USAF, USN, USMC, or USCG abuse cases relocate near Army installations.

(10) Provide medical guidance for installation information and education programs on family advocacy.

(11) Provide advice and guidance on benefits of the Uniformed Services Health Benefits Program.

(12) Maintain confidentiality of information contained in medical records. Release such information according to AR 340–21 and Systems Notice AO917.10 DASG, Family Advocacy Case Management Files.

(13) Insure that all direct services and supervisory staff in the MTF receive appropriate Army family advocacy training. Training and staff development activities must provide for the following:

(*a*) Inservice technical training for counselors and clinical staff assigned to work with the FACMT and to provide clinical treatment services. Special training must be provided to staff who treat batterers (para 7–9).

(*b*) Continuing education and conferences that provide education and training in child or spouse maltreatment education, prevention, and treatment services.

(14) Coordinate all phases of program development with the FAPC to assure that roles and responsibilities for training and counseling services are clearly defined.

(15) Insure that funding for medical facilities and manpower are adequate and comply with DA policy. Assure that activities can be carried out to meet program objectives of the AFAP and that local program needs for required resources are met.

(16) Insure adequate and appropriate medical services and clinical and clerical support are provided to include medical or clinical evaluation, diagnostic assessment, treatment, followup, and reporting.

7–4. Family advocacy case management team (FACMT)

a. Makeup of FACMT.

(1) The FACMT is a multidisciplinary team organized, subject to the direction of the installation commander, and supervised by the MTF commander to assist in the prevention, identification, evaluation, diagnosis, treatment, disposition, followup and reporting of child or spouse maltreatment.

(2) The FACMT is normally chaired by the chief of social work services. Members include the AFAP coordinator, pediatricians, social workers, lawyers, nurses, chaplains, law enforcement personnel, alcohol and drug control officer (ADCO), civilian child protective services workers, and other personnel. All of these members contribute to the evaluation, treatment, and progress of a child or spouse maltreatment case. The FACMT works with the alleged child or spouse abuser's commander or supervisor, the Community mental health activity (CMHA), Child Development Services, Criminal Investigation Command (CID), and on-post schools.

(3) In the absence of a chief of social work services, the FACMT chairperson may be a staff member who has an interest in and knowledge of child or spouse maltreatment. He or she must be in a position to influence the case management process.

(4) The chairperson FACMT will insure that a POC is designated to receive and take initial action on all reports of child or spouse maltreatment referred to the MTF. The chairperson will publicize procedures (in conjunction with the FAPC) for reporting cases of child abuse.

(5) The FACMT with the MTF and installation commander will insure that local written directives are prepared and distributed. These directives will—

(*a*) Identify the FACMT.

(*b*) Describe the purpose and functions of the FACMT in relation to the installation's unique population.

(*c*) State the accessibility of existing facilities and local services programs.

(6) As child or spouse maltreatment are separate problems, the FACMT will have different functions in regard to each. The treatment goal for children is protection and services that help parents to be better parents. The treatment goal for spouses is control of self and life circumstances. Treatment teams may handle each problem separately or two teams could be organized — one to address child abuse and one to address spouse abuse. This regulation has been structured using a single team because resources for two teams may not be available at each installation. It is the installation commander's prerogative to combine or separate child and spouse abuse into one or two teams.

b. Functions of the FACMT. The FACMT will—

(1) Evaluate reports of child or spouse maltreatment to—

(*a*) Identify potential family problems and intervene as necessary to prevent injury to the parties involved.

(*b*) Obtain thorough medical and psychological evaluations of children, parents, or any other persons involved in the incident reported to the FACMT.

(2) Complete and forward DA Form 4461–R (Family Advocacy Case Management Team (FACMT) Incident Report) to the central registry on all child or spouse maltreatment cases (para 7–10). Exceptions are child maltreatment cases that the FACMT has evaluated and determined unfounded. DA Form 4461–R will be reproduced locally on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.

(3) Report all incidents of suspected child maltreatment as quickly as possible to the military police for investigation.

(4) Substantiate the existence or absence of child or spouse maltreatment.

(5) Determine in all cases the nature of the suspected child and spouse abuse and classify it in either an established, unfounded, or suspected category. A followup case management incident report will be submitted after the reported incident is categorized as established or suspected. The followup case management incident report must be submitted within 30 days of the initial report.

(6) Report all suspected and established incidents of child abuse to the local child protective services authority.

(7) Determine disposition of specific child abuse in order to—

(*a*) Designate a case manager.

(*b*) Develop a treatment plan and provide followup services.

(*c*) Review cases at least quarterly to monitor progress in each case and to reassess the treatment plan.

(*d*) Determine whether a court or law enforcement agency should intervene.

(*e*) Report or refer the case to civilian authorities for followup action.

(*f*) Recommend the removal of children from their homes if necessary.

(*g*) Provide recommendations for disposition of the case to the appropriate civilian agency including details of planned followup by the military.

(8) Coordinate service delivery in cases of spouse abuse to—

(*a*) Designate a case manager to develop a treatment services plan and identify necessary legal, medical, and social services.

(*b*) Maintain case records of all case procedures.

(9) Refer a family in treatment to the gaining installation or civilian community, on reassignment, transfer, expiration term of service (ETS), or retirement of the service member. (See para 7–14 for case transfer procedures.)

(10) Recommend to the installation commander alternatives for families who refuse to cooperate with FACMT treatment plans. This could mean expulsion of the family from the military installation and early rotation to CONUS. Such actions will allow the family to come under civil jurisdiction.

(11) Recommend, in cases where a service member refuses to cooperate with treatment plans and further rehabilitation is not considered practical, that the commander consider persuing a separation action (para 7–20).

(12) Insure that the unit commander is advised of disposition of cases involving military persons and their family members. Areas to be covered are expected length of time in treatment, attitude, cooperation, prognosis, and duty limitations. Include ways the commander may cooperate to facilitate the treatment process.

(13) Determine whether the medical record is to be coded as a special category record.

(14) Recommend to the commander, when case status warrants, that action be forwarded to the US Army Military Personnel Center (MILPERCEN). Request that favorable personnel actions be suspended; that personnel be deferred from PCS instruction; or that programed assignment be changed to a location where adequate resources are available to continue the treatment process (sec IV).

(15) Recommend to the installation commander service members whose progress in rehabilitation do not warrant reenlistment.

(16) Recommend closing the case.

(17) Develop local policies and procedures for intervening in cases of abuse by a person not related to the maltreated child (*e.g., babysitter, neighbor*). In such cases, referral to appropriate military or civilian authorities may be necessary.

(18) Coordinate and use available resources (military and civilian) to treat individuals and families referred to the FACMT.

(19) Inform the FAPC and installation commander of problems in the FACMT service delivery system. Recommend specific improvements.

(20) Identify conditions that lead to child or spouse maltreatment and those that hinder reporting, treatment, or disposition of a case. Recommend corrective action to the HR Council to resolve identified problems.

7–5. Involving the installation community in reporting child maltreatment

a. Military and civilian members of the installation community will be encouraged to report all incidents of alleged child abuse to the FACMT POC or to the military or security police. Persons who provide statements in connection with a particular case of suspected child abuse and who request confidentiality will be granted it under the provisions of AR 340–21–9, paragraph 7–4, and Systems Notice AO917.10 DASG, Family Advocacy Case Management File. Their statements will be marked "Confidential" in case records.

b. Installation physicians, nurses, social workers, medical personnel, law enforcement, school officials, and child support services will report all incidents of suspected child abuse. These persons will be granted confidentiality on request under AR 340–21–9 and Systems Notice AO917.10 DASG, Family Advocacy Case Management File.

Section II
Program Components

7–6. Child or spouse maltreatment prevention

a. Maltreatment causes. The AFAP will provide prevention services to alleviate stress, to improve family functioning, to provide support to families at risk (families undergoing the kinds of stress that could trigger abusive or neglectful behavior), and other services that treat or prevent recurrence of abuse and neglect. Research findings have dispelled the myth that families involved in child or spouse maltreatment are mentally ill or criminally motivated. Some of the factors that contribute to the kinds of family violence or parental inattention that result in harm to children and their parents are shown below.

(1) Marital discord.

(2) Financial problems.

(3) Continuous child care responsibility.

(4) Lack of knowledge about childbearing and child rearing.

(5) Social isolation.

(6) Substance abuse.

(7) Stress unique to the military family.

b. AFAP community education.

(1) A community education program will be established to make the community aware of child or spouse maltreatment, how to report it, and what services are available. Emphasis will be placed on prompt identification and referral of suspected cases of child or spouse maltreatment and on self-referral.

(2) Installation commanders are encouraged to sponsor programs such as stress management, communication, child development, and child management training classes.

c. AFAP community resources. In addition to educational efforts, prevention of child or spouse maltreatment requires the development of coordinated community support services to help troubled families through the treatment process. Community resources may include—

(1) Early childhood programs such as family day care and child development services. Such services can alleviate the stress of caring for young children and can provide children with needed structure and stimulation.

(2) Child care services that can provide emergency services when parents are temporarily unable to care for their children.

(3) Self-help groups such as parents anonymous to provide peer support and assistance.

(4) Supportive services for parents such as homemaker services and parent aides.

(5) Special activity programs for children and recreational activities provided on the installation.

(6) A telephone crisis hotline (only if an existing hotline cannot offer the needed services).

(7) Child abuse and neglect helplines to provide the parent or child caller with an empathetic, nonjudgmental listener, and to offer information, and referral services.

d. Identification of at risk families. The AFAP will identify families at risk. These include families with children having special needs, frequent absences of one or both parents, expectant parents, single parents, very young parents, and families with cultural gaps or lower incomes. Such families will be assisted through active education programs and counseling in coordination with appropriate Army and civilian social services agencies.

7–7. Services for children and families

Services that foster changes in parental behavior, parent-child relationships, home environment, and those that offer the maltreated child protection are to be considered in treating the child and the family. Services that may be provided in the community include—

a. Foster care.

b. Day care.

c. Homemaker service.

d. Family planning.

e. Health-related services.

f. Home management.

g. Legal services.

h. Financial planning.

i. Transportation.

j. Special services for the handicapped.

k. Counseling.

7–8. Programs for battered spouses

Programs for battered spouses will be established to encourage individual action and personal growth. Victims must have an escape route or plan of protection in case of further violence. They should be supported in learning ways to let the batterer know that continued violent behavior will not be tolerated. A basic program for maltreated spouses will include—

a. Short term crisis intervention.

b. Emergency housing accommodations and temporary shelter.

c. Counseling.

d. 24-hour hotline.

e. Legal services.

f. Other necessary services such as clothing, transportation, and food.

g. Job readiness and training.

h. Financial counseling.

7–9. Programs for batterers

Programs for batterers that stress the goals of stopping the battering and gaining behavioral control of actions

must be established. Current treatment models view battering as a learned behavior and stress the batterer's ability to learn self-control and behavioral alternatives to violence. Self-help and treatment groups are used to offer support and reinforce the batterer's attempts to learn new behavior.

Section III
Case Reporting Procedures to the Central Registry and Family Advocacy Case Management Team Files

7–10. DA Form 4461–R (Family Advocacy Case Management Team (FACMT) Incident Report)

a. Purpose of DA Form 4461–R. Use this form to obtain an estimate of the amount of child or spouse maltreatment occurring in the Army community and to analyze past incidents of child or spouse maltreatment.

b. Submitting DA Form 4461–R. The chairperson of the FACMT will submit a DA Form 4461–R for every case of child or spouse maltreatment. Appendix B contains specific instructions on how to prepare the form. Various dispositions such as an initial report, followup report, report of a subsequent incident, transfer, and case closure are required.

c. Child maltreatment case reporting.

(1) After preliminary review of every suspected or established child maltreatment case, the FACMT will prepare and submit an initial DA Form 4461–R. An initial report will not be submitted for cases determined to be unfounded during the preliminary review.

(*a*) Cases involving more than one child in the same family will be reported separately.

(*b*) An FACMT case determination is not required prior to submitting the initial report.

(*c*) For all initial reports in which a case determination has not been made, the reporter will enter the classification as suspected.

(*d*) A copy of the initial report should be forwarded within 10 working days following the first presentation of the case to the FACMT.

(*e*) If a case involves USAF, USN, USMC, and USCG personnel or their families, submit two copies of the DA Form 4461–R. The additional copy will be sent to the respective central registries of the Services or to USCG by the Army Central Registry.

(2) A followup incident report will be prepared no more than 30 days after the initial report if case determination is different from that listed on the initial report or if there is new information. Followup reports must be submitted on specific cases to update or clarify the information contained in the central registry. The followup report will indicate the determination made by the FACMT.

(*a*) If the FACMT makes a determination of unfounded, all information regarding the case will be destroyed at the local installation level. The local installation will send a DA Form 4461–R indicating a case determination to the central registry. When the central registry receives the DA Form 4461–R, all central registry information pertinent to the case will be destroyed.

(*b*) The FACMT must insure that prompt assessments are made. Important considerations in the assessment and case management process include insuring that services are comprehensive, equitable, and continuous until the case is closed.

d. Spouse abuse case reporting. A DA Form 4461–R must be submitted for each case of spouse abuse. The report will be submitted when a case is opened, when a case is closed, or when a change such as a reassignment occurs.

e. Incident report summary data. Installation FACMTs will maintain and furnish to the installation ACS officer summary data on FACMT incident reports to fulfill the reporting requirements of DA Form 3063–R (Army Community Service Program Report).

f. Initial and followup FACMT incident reports. A copy of DA Form 4461–R will be forwarded to: Commander, US Army Patient Administration Systems and Biostatistics Activity, ATTN: HSHI, QPD (AFAP), Fort Sam Houston, TX 78234. These reports will be compiled and maintained in the central registry.

7–11. Army Central Registry

The functions of the central registry are to—

a. Receive and enter into the registry all reported child or spouse maltreatment cases from DA Form 4461–R; maintain this information; and compile statistical data on caseloads and trends for management purposes.

b. Maintain reports of child or spouse maltreatment so as to respond to installation FACMT inquiries regarding prior incidents of abuse.

c. Forward a copy of the DA Form 4461–R to the family advocacy office of the appropriate military service in all cases involving the family of a member from another service.

d. Maintain information in the central registry according to File No. 917–10 (Family Advocacy Case Management Files), AR 340–18–9.

e. Destroy all central registry information pertinent to a specific case after an installation FACMT determines that a suspected case is unfounded. This information reaches the central registry on a followup FACMT incident report.

7–12. Retrieval of central registry information

a. Access to the central registry. Access will be closely monitored.

(1) Written access to the central registry must conform to the following procedures.

(*a*) Official requests for information by the FACMT will contain the full name, social security number, official job title, and duty telephone number of the person requesting the information. The reason for the request and the social security number of the sponsor of the family member who is subject to the inquiry will be included.

(*b*) Request for information will be sent to Commander, US Army Patient Administration Systems and Biostatistics Activity, ATTN: HSHI, QPD (AFAP), Fort Sam Houston, TX 78234.

(*c*) Written responses will be forwarded to the Chief, MTF, Patient Administration Division, to be transmitted directly to the chairperson of the FACMT or the FACMT POC.

(*d*) Individuals seeking access to the information contained in their FACMT case files will be referred to AR 340–21–9.

(2) Telephonic access to the central registry will conform with the following procedures:

(*a*) Authorized representatives of the installation FACMT will telephone the central registry and give the social security number of the sponsor of the family member who is the subject of the inquiry and the name of the inquirer. No other information will be provided or discussed during this initial telephone conversation.

(*b*) The chairperson of the FACMT will provide the Chief, MTF Patient Administration Division (PAD) with a list of local personnel authorized to receive central registry information.

(*c*) Commander, US Army Patient Administration Systems and Biostatistics Activity, ATTN: HSHI, QPD(AFAP), Fort Sam Houston, TX 78234, will respond to the FACMT inquiry by return telephone call through the MTF PAD. The MTF will develop local procedures for referring the telephone call or information from PAD to the FACMT. These procedures will include provisions io insure that all transactions with the central registry are conducted only by authorized personnel and in confidence.

b. Research requests. Research requests will be made in accordance with AR 40–66. Information for research purposes must be requested through HQDA(DAAG–PSC), ALEX VA 22331.

7–13. Establishment of FACMT file

a. An FACMT file will be prepared for each person treated or evaluated for suspected child or spouse maltreatment. It will be maintained as directed by the chairperson of the FACMT per File No. 917–10, AR 340–18–9.

b. Access to the FACMT file will be limited as prescribed in AR 340–21–9 (Systems Notice AO917.10 DASG, Family Advocacy Case Management Files).

c. The FACMT file will contain the following information:

(1) Copies of Standard Form (SF) 600 (Chronological Record of Medical Care).

(2) Copies of all DA Form 4461–Rs submitted.

(3) Copy of initial case presentation of FACMT.

(4) Copies of case minutes taken at the FACMT meeting.

(5) Social work assessment.

(6) Health nurse report if applicable.

(7) Photographs.

(8) Copy of X-ray results.

(9) Copy of blood and other test results.

(10) An extract of pertinent data from the military police report, CID report, and other investigative reports.

(11) Copy of SJA action.

(12) Reports from local child or spouse abuse sources.

(13) Other information that is pertinent to the case.

7–14. Transfer of FACMT file

a. Perform the following actions for open cases when the service member and family members are being reassigned and the servicing FACMT determines that a referral should be made:

(1) The losing FACMT will prepare a transfer of FACMT file letter. A sample format is at figure 7–1. This letter will be sent to the gaining FACMT.

(2) The gaining FACMT will comply with the instructions in the transfer letter. It will complete the inclosure to the transfer of FACMT file letter and return it to the losing FACMT. A sample format is at figure 7–2.

(3) On the departure of the family, the losing FACMT will complete and submit a DA Form 4461–R per instructions for transferring out an open case.

(4) On receipt of the reply from the gaining FACMT, the losing FACMT will mail the FACMT file by certified mail, attaching a Postal Service (PS) Form 3811 (Return Receipt). This form may be picked up from any Post Office.

(5) The gaining FACMT will complete the PS Form 3811 acknowledging control of the file and mail the card.

Note: These three items— a copy of the transfer of FACMT file letter, the return letter from the gaining FACMT, and the PS Form 3811—will document that a successful transfer has been accomplished.

b. When the family arrives at the new installation, the gaining FACMT will complete and submit a DA Form

4461–R per special instructions for transferring in an open case (app B).

c. In accordance with AR 340–18–9, keep the files on the following cases:

(1) Cases that are closed when the service member and family members are reassigned.

(2) Cases that the servicing FACMT determines do not need to be forwarded.

d. When cases are transferred to Europe, the transfer letter will be sent to the Commander, 7th Medical Command, ATTN: AEMPS–C–SW, APO NY 09102. The command will—

(1) Ascertain the final assignment of the service member.

(2) Determine the servicing MTF based on the service member's need for services.

(3) Return the inclosure to the losing MTF so that the losing MTF may send the case record to the gaining MTF.

7–15. FACMT performance evaluation

An evaluation of the FACMT performance must be completed at least once a year, when a new chairperson assumes the position, or as directed by the MTF commander. The evaluation must review the FACMT's organization, coordination with civilian services, effectiveness of case management, and responsiveness. The FACMT performance evaluation provides an example of a self-evaluation the FACMT may use to quickly identify areas for improving current performance. A sample format is at figure 7–3.

Section IV
Reassignment, Promotion, Reenlistment, and Separation Actions

7–16. General

Guidance on the reassignment, promotion, and reenlistment of Army personnel suspected of child or spouse maltreatment is given here. See AR 600–31 for guidance concerning suspension of favorable personnel actions for service members who are undergoing military police or CID investigation.

7–17. Reassignment, deletion, or deferment

Guidance regarding reassignment, deletion, or deferment is in AR 614–200, chapter 3; AR 614–30; and DA Pam 600–8–10. The FACMT will make a recommendation on the prognosis of family members in treatment as a result of child or spouse maltreatment. The recommendation should be made before a decision for reassignment, deletion, or deferment is made.

7–18. Promotions

Promotions are based on a service member's performance of duty and demonstrated potential for service in positions of increased responsibility. Participation in the AFAP will not make a service member ineligible for consideration for promotion.

7–19. Reenlistment

Reenlistment should not be denied child or spouse maltreaters solely on the basis of entering treatment. However, a bar to reenlistment may be recommended to the commander by the FACMT.

7–20. Separation actions

When further rehabilitation is not practical, recommend that the chairperson, FACMT, contact the commander and suggest that separation actions based on child or spouse maltreatment be initiated. The following procedures are suggested:

a. Consult with SJA for legal restrictions.

b. For officer separations, see AR 635–100.

c. For enlisted personnel separations, see AR 635–200.

Subject: Transfer of Family Advocacy Case Management Team Files

To: Family Advocacy Case Management Team

1. In accordance with AR 608–1, you are advised that _____ (Name),

_____ (Rank), _____ (SSN), has been reassigned to your area of responsibility with a report of _____.

2. _____ (Rank) _____ (Name) has been assigned to _____ (Unit name and address).

3. It is the opinion of the FACMT that further treatment or attention is warranted.

4. Request the enclosed form letter be completed and returned to this office as soon as possible.

5. Point of contact is _____ (Rank and name), _____ (Telephone number).

1 Incl
(return letter from
the gaining FACMT)

Signature
Chairperson, FACMT

Figure 7–1. Sample letter for transfer of FACMT file

Subject: Case Name and SSN

To: Losing FACMT, MTF

Have received your letter of case transfer and request you forward the case file to the following address:

_____

_____

_____

_____

Received your letter of case transfer and currently unable to locate subject in question. Please advise further if necessary.

Signature
Chairperson, FACMT

Figure 7–2. Sample return letter from the gaining FACMT

Purpose. The FACMT performance evaluation provides the FACMT with a self-assessment that quickly identifies areas for improvement. The FACMT performance evaluation can be easily used by anyone to assess the committee's status. It can be particularly useful to an incoming chairperson of FACMTs, the IG team during their visits, and to other interested personnel.

Scores. A team's total FACMT performance evaluation score is the sum of organization, function, and administration points. A "yes" answer to each organization item yields 5 points, a "yes" answer to each function item yields 4 points; and a "yes" answer to each administration item yields 3 points. A "no" answer yields 0 points and indicates an area in need of improvement.

Summary	*Points*
Organization	____/30
Function	____/40
Administration	____/30
	_____
	____/100

Organization

	Yes	*No*
1. *Interdisciplinary Mix.* The team has a complete interdisciplinary composition according to the available professional resources.	____(5)	____(0)
2. *Written Directive.* There are one or more local written directives (e.g., SOP, MTF regulation, post regulation) establishing the FACMT and describing its function.	____(5)	____(0)
3. *Committee Minutes.* Minutes of team meetings are authenticated by an appropriate authority and maintained properly.	____(5)	____(0)
4. *Leadership.* Formal team leadership is established (e.g., chairperson, coordinator, alternates).	____(5)	____(0)
5. *Civilian Agencies.* A satisfactory working liaison is established with local civilian child protection agencies.	____(5)	____(0)
6. *Committee POC.* A well-publicized point of contact for information and case reporting is named.	____(5)	____(0)

Organization Total Pts = _____

Figure 7–3. FACMT Performance Evaluation

Function

	Yes	*No*
1. *Case Record.* There is a case record for every case handled by the team.	___(4)	___(0)
2. *Central registry.* Each case that meets the established guidelines is reported to the Army Central Registry (Fort Sam Houston, TX).	___(4)	___(0)
3. *Treatment Plan.* A treatment plan is developed for each case and is part of the FACMT case record.	___(4)	___(0)
4. *Case Manager.* A case manager is appointed for every case.	___(4)	___(0)
5. *Case Revision and Update.* There are established procedures for revising and updating cases periodically.	___(4)	___(0)
6. *Initial Medical Examination.* There are guidelines for use by medical personnel in their initial examination of the child (e.g., whom to contact).	___(4)	___(0)
7. *Psychosocial Assessment.* There are guidelines for use by behavioral science personnel in their assessment of the child and family.	___(4)	___(0)
8. *Home Visit.* There are guidelines for use when in-the-home assessment and therapeutic intervention is required.	___(4)	___(0)
9. *AFAPC and Command.* There are procedures that define and improve relations among the team, AFAPC, and post commander.	___(4)	___(0)
10. *Local and State Registries.* Requirements for reporting cases to local and State registries are met.	___(4)	___(0)

Function Total Pts = _____

Figure 7–3. FACMT Performance Evaluation—Continued

Administration

	Yes	*No*
1. *Military Community Support.* In general, the military community and agencies support the FACMT effort.	____(3)	____(0)
2. *Civilian Community Support.* In general, the civilian community and agencies support the FACMT effort.	____(3)	____(0)
3. *Case Transfer.* The committee adheres to established procedures for transferring cases to and from other FACMTs.	____(3)	____(0)
4. *Clerical Support.* The FACMTs receive adequate and dependable FACMT's clerical support.	____(3)	____(0)
5. *Orientation.* All newly assigned commanders, staff, and military community members receive adequate orientation to the FACMT effort.	____(3)	____(0)
6. *Prevention.* There is a postwide child abuse prevention and awareness project.	____(3)	____(0)
7. *Responsiveness.* There are procedures that insure timely response to case report sources.	____(3)	____(0)
8. *Training.* New FACMT members receive adequate local training, and experienced members have access to continuing education.	____(3)	____(0)
9. *Consumer Evaluation.* When possible, evaluation of the effectiveness of the intervention is solicited from the child, the sponsor, and the maltreater.	____(3)	____(0)
10. *Performance Evaluation.* There are procedures used by the team to assess its performance and effectiveness periodically.	____(3)	____(0)

Administration Total Pts = _____

Figure 7–3. FACMT Performance Evaluation—Continued

Chapter 8
Exceptional Family Member Program

Section I
General

8–1. Relocation at Government expense

Service members eligible to relocate their families at Government expense should identify family members with physical, emotional, or intellectual disorder or gift or talent to assignment authorities according to AR 614–203. This information will be considered when assignment decisions are being made.

8–2. Program objectives

As part of the exceptional family member program ACS will provide support to assignment authorities reassigning service members who have exceptional family members. ACS will insure, when possible, that service members receive the information and assistance needed to involve family members in specialized programs and services designed to meet their needs.

Section II
Program Components

8–3. Information, referral, and placement

a. All ACS centers will maintain a listing of military and civilian special education and health-related services. All 50 States' health-related data will be collected by ACS centers in coordination with regional Army Medical Centers on DA Form 4723–2–R (Health-Related Survey—Individual Facility Report). Definitions in DA Form 4723–2–R must be used in conducting the survey. Civilian special education data in all 50 States will be collected from existing information data bases. OCONUS (excluding Alaska and Hawaii) special education and health-related data will be collected by the Department of Defense Dependents' Schools (DODDS) and the Office of The Surgeon General (OTSG).

b. Each ACS center in every State will furnish a report of health-related and special education services to HQDA(DAAG–PSC) on DA Form 4723–1–R (Report of Health-Related Services for the Exceptional Family Member) and DA Form 4723–R (Report of Special Education Services for the Exceptional Family Member). The data collected on DA Form 4723–2–R will be used to complete DA Form 4723–1–R. Definitions of handicapping categories in DA Form 4723–R must be used in preparing form.

c. Special education and health reports (DA Forms 4723–R and 4723–1–R) will be prepared semiannually. The first report will cover the 6-month period 1 October through 31 March. The second report will cover from 1 April through 30 September.

d. MACOM commanders will forward the reports to HQDA(DAAG–PSC), ALEX VA 22331, to arrive not later than 15 days following the end of the reporting period.

e. DA Forms 4723–R, 4723–1–R, and 4723–2–R will be reproduced locally on 8½- by 11-inch paper. Copies for reproduction purposes are located at the back of this regulation.

f. In response to specific request for assistance, installation ACS centers will provide direct casework services for personnel assignment authorities by researching the availability of programs and facilities in their regional areas and by reporting on the availability of actual openings in those programs.

8–4. Provision of recreational and cultural programs

a. In the absence of recreational and cultural programs in the military and civilian community, ACS and morale, welfare, and recreation (MWR) activities will sponsor activities for handicapped family members. These activities will include sports (basketball, volleyball, soccer, swimming, and bowling), camps, art, music, and dance therapy.

b. Coordination of activities with local universities, State parks, recreation departments, and other civilian resources will be required.

8–5. Respite care

a. If not available or accessible in the civilian community, the ACS center will establish and maintain a respite care program for handicapped family members. Such a program will provide a rest period for family members responsible for regular care of the handicapped person.

b. Two levels of care will be available according to the needs of handicapped family members. These are supervision only, and supervision with personal care. Respite care is provided on an hourly, daily, or weekly basis. It may be provided either in the respite care user's home or a caregiver's home, approved by ACS.

c. Dependable, caring individuals motivated by a desire to serve handicapped family members will be recruited from the community. They will be screened, trained, and certified by ACS. Although caregivers are not employees of ACS, they must perform according to the standards established by ACS when providing a respite care service.

(1) Caregivers will be at least 18 years old and in good physical and emotional health.

(2) DA Form 5187–R (Application for Respite Caregivers) and DA Form 5188–R (Medical Report on Applicant for Certification to Provide Care for Handicapped Children or Adults) will be completed and returned to ACS by prospective caregivers within 30 days of initial contact. DA Forms 5187–R and 5188–R will be reproduced locally on 8½- by 11-inch paper. Copies for reproduction purposes are located at the back of this regulation. At least one in-person interview is required. Use sample format (Caregiver Screening Interview) at figure 8–1 to record data.

(3) Information will be obtained from three written references regarding the prospective caregiver's ability to provide care.

(4) If providing out-of-home care for children, caregiver homes will meet requirements for special needs family child care homes.

d. Training will be completed prior to providing respite care. An orientation respite care course outline as shown in sample format, figure 8–2. Coverage of these subjects will insure uniformity of respite care training throughout ACS. Training will provide the necessary framework of knowledge required for efficient participation in the program. A minimum of 12 hours of instruction and discussion are required for a course certificate.

e. Respite care users will register for the program by completing DA Form 5189–R. (Application for Respite Care for Handicapped Children and Adults) and DA Form 5190–R (Clinician's Information) and returning it to ACS. After the completed forms are returned, the respite care worker will make at least one home visit. Use sample format (Care User Screening Interview) at figure 8–3 to record interview contact. Written notification will then be sent to the applicant confirming eligibility or ineligibility for respite care. Approved respite care users must sign the Respite Care Agreement, sample format (fig 8–4). In addition, they must have DA Form 5191–R (Information on Handicapped Individual) available for the respite caregiver. DA Forms 5189–R, 5190–R, and 5191–R will be reproduced on 8½- by 11-inch paper. Copies for reproduction purposes are located in the back of this regulation.

f. Families and caregivers will set the rate for the care provided. Payment for services will be made directly by the families to the caregivers at the end of each respite period.

8–6. Advocacy

Families with exceptional members will be informed of their rights and responsibilities under local and Federal laws and the type of community services available to meet their needs.

8–7. Child-find activities

ACS will assist education systems in identifying children with handicapping conditions. Sources of identification include— parents, child care personnel, and professional persons in the community. With consent of the parents, ACS will forward the name of identified child and date of birth, parent's name, address, and phone number to the State Department of Education or DODDS for evaluation. State departments of education should be contacted for POC within CONUS. In oversea areas, ACS should contact appropriate DODDS regional offices.

Date:
Name:

IDENTIFYING INFORMATION

Age, Sex, Race, Occupation, Referral Source

SUMMARY OF CONTACTS

Where, When, Context

BACKGROUND

Born—Where, When
Family Situation—Parents:
Siblings:
Closeness, Location:
Education History:
Employment History:
Marital Status:
Religion:
Health:
Past Criminal Arrests or Convictions:

PRIOR EXPERIENCE (Volunteer, Paid Courses)

PRESENT SITUATION

Employed or in School:
Source of Income:
Motivation:

SELF ASSESSMENT

Strengths:
Weaknesses:
Ability to handle emergencies:

PREFERENCE AND AVAILABILITY

Ages:
Handicapping Conditions:
Day and Hours:
Transportation:
Personal Care:
Subsidized Families:

SUMMARY AND RECOMMENDATIONS:

Figure 8–1. Caregiver Screening Interview

First Evening (3 hours)

Purpose of Respite Care
Basic Understanding of Developmental Disabilities
Emotional Aspects of Respite Care
First Aid Course

Second Evening (3 hours)

Seizure Disorders
Medication
Special Feeding Problems

Third Evening (3 hours)

Behavior Management
Prosthetic Appliances

Half-day (Morning or afternoon)

Tour multihandicapped public school, vocational training center, or sheltered workshop

Figure 8–2. Respite care course outline

NAME:

ADDRESS:

PHONE:

I. SUMMARY OF CONTACTS

II. PRESENTING REQUEST

III. HOUSEHOLD COMPOSITION

CLIENT:

OTHER FAMILY MEMBERS:

IV. INCOME

V. DESCRIPTION OF DISABILITY

VI. SOCIAL HISTORY

VII. SUMMARY AND RECOMMENDATIONS:

Figure 8–3. Care User Screening Interview

As a condition of receiving respite care services for the handicapped individual in my/our care, I/we agree to the following:

I/we shall not hold the _____ responsible or liable in any way whatsoever as a result of any incident which might be construed to affect adversely the health, safety, or welfare of the handicapped person or other member of the same household in the caregiver's change, while he or she is cared for by a respite caregiver.

I/we shall provide the Respite Care Coordinator and caregivers of the Respite Care Program with all the necessary facts to enable the handicapped individual to be cared for in a healthful, safe, and responsive manner including:

Clear, written instructions on medical care and the giving of medication.

Where I/we can be reached while the handicapped individual is in the caregiver's charge, and the names and telephone numbers of an emergency contact and physician.

Clear, written descriptions of the special needs, capabilities, likes and dislikes, important habits, etc., of the handicapped individual.

I/we shall make the final decisions whether or not to utilize the services of a particular caregiver for the respite period.

I/we shall inform the Respite Care Coordinator of other household members who will also need care or supervision in my/own absence, and of any special household circumstances about which a caregiver would need to be aware.

I/we shall pay the contribution agreed upon directly to the caregiver in cash, upon completion of the respite period.

The Respite Care Coordinator shall have my/our permission to arrange for an alternate caregiver for our handicapped family member, if he/she is unable to contact us (or the person designated by us as responsible in our absence) to inform us that the caregiver initially providing care is unable to complete the respite period.

I/we shall provide on request to the Respite Care Coordinator my/our assessment of the performance of a caregiver who has provided a respite care service to me/us in order to assist him/her in evaluating the overall performance of that caregiver and/or the program.

_____ _____

(Parent, Guardian, or Responsible Family Member) (Date)

_____ _____

(Respite Care Coordinator) (Date)

A copy of this agreement, signed by the Respite Care Coordinator, will be returned to you on the approval of your application.

Figure 8–4. Respite Care Agreement

Chapter 9
Foster Care Program

Section I
General

9–1. Concept

Foster care is a voluntary or court mandated program. It provides—

a. Twenty-four hour care in a foster family home or group facility for children who cannot be cared for by their natural family. Foster care is provided for as long a period as children need substitute care.

b. Supportive help to the foster parents and supervision of children to insure that the placement promotes the well-being of the children in growth and development.

c. Periodic review of the placement.

d. Special services to the children (e.g., social work, psychological, psychiatric, and educational services).

e. Additional time and skill for foster parents to help children cope with a handicap or severe emotional or behavioral problem.

f. Social work assistance to natural parents in resolving problems that made foster care necessary and to help them resume their parental responsibilities. If the return is not possible, other long-range plans must be made for their children.

g. Consultation about the appropriateness of return for a limited time after the return of children to their own home or the home of relatives.

9–2. Objectives of foster care

The objectives of foster care include—

a. Providing foster family or group care for children whose parents or relatives cannot maintain a home for them in accordance with their individual needs.

b. Placing children who need foster care in a stable permanent arrangement as soon as possible.

9–3. Application

a. ACS will establish a foster care program per local, State, and host nation guidelines. If foster care services are available and accessible through the local civilian authority, these services should be used. ACS must write an SOP outlining use of the civilian foster care services and appoint a POC to insure continuity of care and coordination of casework services. If civilian guidelines do not exist, follow policies and procedures in section II in implementing the program.

b. A child may be placed in foster care only when—

(1) There is an application signed by the parent or an adult standing in place of the parent.

(2) The civilian child welfare placing agency has authority because of court commitment or emergency (such as abandonment) pending court action.

c. When one or both parents apply for voluntary placement of a child, placement will be made if the following conditions are met:

(1) If available, both parents sign the application unless one parent has the authority to act alone. A parent is considered unavailable if whereabouts are unknown. A parent has the authority to act alone when he or she has legal custody of the child or paternity has not been established.

(2) If available, both parents must agree to the child's placement when custody has not been clearly established as belonging to one or the other.

(3) The civilian child welfare placing agency indicates that one or both parents can function responsibly in relation to their children and the agency. The financial status of the parent is not a determining factor in accepting the child for voluntary placement if the above conditions can be met.

d. A final decision concerning on-post placement will be based on the recommendation of the foster care coordinator and civilian child welfare agency and approved by the installation commander. Normally, there is consent of the natural parents or legal guardian.

9–4. Consent for medical care

a. Natural parents will participate, if capable and available in plans for the medical care of the child whether court committed or in voluntary placement.

b. Parents who place a child voluntarily with ACS will provide medical records and written consent for routine medical care and hospitalization.

9–5. Resources for reimbursement towards cost of care

Natural parents will reimburse ACS or the civilian welfare agency the full amount, when possible, for ordinary expenses in providing for the children. If there are any extraordinary expenses (i.e., medical), they should be paid by the natural parents. Should the natural parents be financially unable to reimburse ACS, the foster parents will be paid from ACS APF. The amount of payment is determined by State or local regulations.

Section II
Program Components

9–6. Prevention of placement

a. ACS will make available, through its own resources and in coordination with other agencies, a full range of services designed to prevent the need for placement. These services include—

(1) Social work and counseling services.

(2) Psychological services.

(3) Economic assistance, including emergency short term funds.

(4) Employment preparation, job training, and education services.

(5) Housing and transportation services.

(6) Homemaker services.

(7) Medical services, including outpatient psychiatric care.

(8) Day care.

(9) Child management training and parent support groups.

(10) Respite care.

b. ACS will use a comprehensive emergency services system. The system will consist of—

(1) Intake services, 24 hours a day, 7 days a week.

(2) Caretaker services for children left without parental supervision.

(3) Homemaker services available on a 24-hour basis.

(4) Foster family homes for children who cannot be maintained in their own home.

(5) Family shelter for such catastrophies as fire or eviction.

(6) Outreach and followup services to maintain contact with families after the emergency has passed.

9–7. Preplacement services

a. ACS preplacement policies, procedures, and services will be designed to achieve the following goals:

(1) Help the child and his or her own family understand the significance of the placement decision and what separation may mean for them.

(2) Help the child and its own family understand the ramifications of court commitment or voluntary placement agreement.

(3) Select a foster family home that is consistent with the child's needs.

(4) Prepare the child for placement in a new environment.

b. Selection of a foster family home that will best meet the needs of the child is a key task during the preplacement period. ACS will insure that the child and family are fully involved in making this decision to the extent that they are willing and able to participate. Factors such as the child's age and ACS' ability to locate the family will be considered to determine if the child and family will be involved in selecting a foster family home. Mutual determination will be made of which home best meets the needs of the child. Placement will be based on the following considerations:

(1) The extent to which the interests, strengths, and abilities of the foster family enable them to relate to the child's needs. Factors include age, interests, intelligence, religious, and cultural background.

(2) The ability of the foster family to support the child's racial, cultural, ethnic, and religious heritage.

(3) The capacity of the foster family to deal adequately and comfortably with problems that might arise during the child's placement.

(4) The extent to which the foster family can contribute to the development of the child and help to alleviate specific problems.

(5) The extent to which the foster family can accept the child's relationship with his or her own family and can deal adequately with situations that may arise from the relationship.

(6) The foster family's potential for providing permanent care to a child who requires such care.

(7) Proximity of the foster home to specialized services or facilities that the foster child may need.

(8) Personal appeal of the child to the foster family and vice versa.

c. The following preplacement services will be provided to the child:

(1) At least one preplacement visit between the child and the foster family. The timing and number of preplacement visits will take into account the child's ability to accept and understand new situations. There may also be other events occurring in the child's life during the preplacement period.

(2) Health assessment and any needed immunization by a qualified health professional prior to placement or in emergency situations within 72 hours following placement.

(3) Psychological assessment and psychiatric evaluation, if indicated.

(4) Mutual determination of what the child will take to the foster home will be made, such as significant names, dates, pictures, and physical possessions.

(5) Planning for visits between the child and his or her own family.

(6) Involvement of the child's present and future schools so the child's social, educational, and extracurricular needs will be met.

d. Emergency placements will include as many of the above procedures in *c* above as possible.

e. Preplacement services for the family will provide them with an understanding of what the placement may

mean for them and the child. It will also prepare the family for its role throughout the placement period.

(1) The child and family will be involved in developing the service plan, including the visitation plan, or in revising the service plan to incorporate the placement decision.

(2) Information about the child's and family's legal rights and responsibilities, the mutual expectations of the agency and the family, and agency policies will be discussed and reviewed.

(3) ACS will encourage the family to identify the general characteristics of foster homes that might be appropriate for the child. When there are several potential homes appropriate for the child, the family will be encouraged to assist in choosing the specific home.

(4) Provisions for medical care of the child will be discussed.

(5) The family's concerns about the foster family's race, religious affiliation, and ethnic origin will be discussed. Provisions will be made for maintaining the child's racial, cultural, ethnic, and religious identity.

(6) The family's financial obligations for the child while in placement will be discussed and resolved.

9–8. Placement services

a. Services will be provided to the child on a regular and planned basis according to the service plan and established ACS policies. Placement services for the child will be designed to achieve the following objectives:

(1) Help the child express and cope with his or her feelings about being separated from the family so that these feelings will not interfere with making the placement a constructive experience.

(2) Provide the child with opportunities to express concerns he or she is unable to discuss with foster parents and to help the child to bring these concerns to the foster parents.

(3) Develop the child's understanding of the conditions that necessitated placement, and to help deal constructively with them.

(4) Meet the needs that arise from the child's normal growth and development.

(5) Help the child to understand and deal with stress situations that may need special attention. These include loss, separation, medical care, hospitalization, social, and school problems.

(6) Help the child with special needs or plans such as peer relationships, planning for vocational or higher education, and planning for independent living.

(7) Prepare the child for visits with family; to use these occasions constructively; and to help deal with the feelings that may result from family visits.

(8) Prepare the child to return home.

(9) If permanent separation from the child's own family is the plan, to help the child understand the reason for that plan.

b. ACS will insure that the following services are available to children in foster care, subject to resource constraint:

(1) Emergency medical services available 24 hours a day, 7 days a week; routine and preventive medical, dental, visual, and hearing examinations, and immunizations recommended by professionals in each field providing the service; and medical care on a planned or emergency basis for all ill children.

(2) Special services for children with chronic health problems, mental or physical handicaps, or learning disabilities.

(3) Psychiatric diagnosis and treatment services.

(4) Educational opportunities in accordance with the child's individual needs and potential.

(5) Career planning for high school age children.

(6) Religious experience that reflects the religious preference of the child and family.

(7) Recreational opportunities that allow for the development of social skills.

(8) Clothing appropriate to the child's age and size and equipment for special needs and activities.

c. Well-planned placement services will be provided to the family on a regular basis in accordance with the service plan and established ACS policies. These services will be designed to accomplish the following objectives:

(1) Help the family to improve the conditions that necessitated placement.

(2) Plan and execute a carefully worked out program of family and child communication and visitation that will help to develop and maintain a constructive relationship between the child and family.

(3) Help parents fulfill their parental roles and responsibilities to the placed child.

(4) Help the family to accept the service plan.

(5) Help the family use community resources.

(6) Help the family to prepare for the child's return home or, if return home is not possible, to involve them in making an alternate plan.

(7) Help the family to achieve a positive self-image in light of the decision to place, especially if the plan for the child includes permanent separation from his or her own family.

d. ACS will insure that a full range of services is provided to the family while the child is in placement. The services described in paragraph 9–6, will serve as a guide to ACS in developing its service plan. ACS, however, will recognize that each family is unique and that services should be based on an assessment of each family's strengths and limitations.

9–9. Agency involvement with and support for foster families

ACS will actively involve the foster family in the preplacement and placement process. It will provide support to the foster family to make the placement a constructive experience.

a. The following kinds of support will be provided to the foster family:

(1) Procedures to insure that on-call assistance is available to the foster family 24 hours a day, 7 days a week.

(2) Procedures that clarify the responsibilities of ACS, the child's family, and the foster parents for authorizing and obtaining medical care for the child.

(3) ACS policies that mandate the involvement of the foster parents in the development and periodic review of the service plan for the child and his or her own family.

(4) Assistance to the foster family in dealing with any problems that may occur during the child's placement.

(5) Assistance to the foster family in helping the child to resolve problems that may arise during normal growth and development, and assistance in helping the child with any special problems.

(6) Provisions of support to the foster family to help them and the child cope with feelings of separation and grief when a child is to leave its home.

b. ACS will help the foster family make an informed decision regarding their acceptance of a particular child. ACS will also consult with the foster family in evaluating the meaning and relevance of any information. The following information will be provided to the foster family:

(1) Strengths, needs, and general behavior of the child.

(2) Circumstances that necessitated placement.

(3) Information about the child's family and relationship to own family that may affect the placement.

(4) Important life experiences and relationships that may affect the child's feelings, behavior, attitudes, or adjustments.

9–10. Termination of placement

Termination of a placement may occur when the child returns to its own home or is placed with relatives; when the child is adopted; when the child reaches age of majority and chooses to live independently; or when the child is placed in another foster home or alternate living facility, such as a group home. Services provided during the transition period will be designed to prepare all parties for the separation and help them cope with their feelings about it.

a. Except in emergency situations, the following policies will be used to prepare for termination of a placement:

(1) Termination of a placement will be anticipated as part of the service plan for the child and its own family. Preparation for this event will begin well in advance of the expected date of termination.

(2) ACS will give the foster family at least a 2-week notice prior to removal of the child and will work with them and the child to make the transition as smooth as possible.

(3) Foster parents who request termination of a placement will give ACS at least a 2-week notice and will participate in planning for removal of the child from its home.

(4) The plan following termination of a placement may be to place the child in another foster home, in an adoptive home, or in the home of a relative that the child does not know well. Then the process outlined in paragraph 9–9 will be followed since replacement can be just as difficult for a child as a first placement. During the transition from one foster family to another living arrangement, special emphasis will be placed on adequate communication among the foster family, the parents, the child, the new caregivers, and the ACS.

(5) Foster parents will be provided with information about ACS grievance procedures should they disagree with the service plan for the child.

b. ACS will provide each child with the kind of support and assistance needed to prepare for the termination of a placement. Support will include—

(1) Assistance with understanding how the child's own family has been able to make a plan for return home.

(2) Support and assistance in working out feelings about being separated from the foster family.

(3) Pretermination visits with own family or with the family with whom placement is being made.

(4) Planning for continued visits with foster family, if such visits are desirable.

(5) Special assistance to children moving into independent living situations will provide—

(*a*) Help in securing safe and decent housing.

(*b*) Assistance in finding employment or other means of support.

(*c*) A plan for vocational training or other higher education.

9–11. Postplacement services

a. Postplacement services will be provided for children and families to assist with their adjustment and to prevent the recurrence of the circumstances that led to placement. Postplacement services will be provided until—

(1) Services are no longer needed.

(2) Services are terminated by the court.

(3) Parents who placed their child voluntarily request that the services be terminated.

(4) A young adult reaches the age of majority and requests that services be terminated.

b. Postplacement services will be planned to meet the individual needs of each child and its own family and each young adult. The following services will be included:

(1) Assistance in understanding new family roles and behavior after a child returns home.

(2) Support for parents who are trying out newly learned, positive child rearing behavior and applying newly acquired knowledge of child development.

(3) Supportive peer group experience for children and parents to reinforce their efforts to create a more constructive family situation.

(4) Assistance to young adults in finding community resources that can support their independent life styles and aid their reentry into the community.

c. ACS may provide postplacement services directly or transfer service provision responsibility to another agency when the situation warrants.

d. ACS will insure that young adults who reach the age of majority and are no longer eligible for foster family postplacement services are aware of other services offered. The ACS or related agencies can assist the individual with the transition from foster family care to independent living.

e. ACS will be available to help former foster children and their families in understanding and accepting the circumstances of the child's having been in foster care.

9–12. Recruitment of foster families

A continuous recruitment effort will be made to arrange foster homes that can provide the full range of services.

a. Recruitment will be based on ACS assessment of community needs and available resources.

b. The recruitment program will be publicized using the media. ACS will also use current foster parents and volunteers to recruit new foster families.

c. The recruitment program will realistically present the abilities needed to provide care for special kinds of children. These include children with physical disabilities, mentally impaired children, and emotionally disturbed children.

d. When possible, cooperate with other agencies to recruit foster families.

e. The effectiveness of the recruitment program will be periodically evaluated by people with expertise in public relations and social services and by foster parents. Determination of effectiveness will be based on approval and turnover rates for recruited families. There will also be an assessment of the extent to which the results of the recruitment program match the service needs of families.

9–13. Screening and followup

a. ACS will establish contact with potential foster families as quickly as possible following the initial indication of interest.

b. ACS will followup the initial contact with an individual or group meeting, designed to have applicants understand ACS eligibility criteria and the evaluation process.

c. The screening process will provide potential foster parents with information to help them decide whether or not they wish to be considered for a study.

d. ACS will make a special effort to followup recruitment efforts promptly with families who qualify for foster care services.

e. Within 15 days after the initial screening, ACS will decide whether or not it will conduct a study of an applicant family. Each family will be notified of this decision orally and in writing.

9–14. The evaluation process

The purpose of an evaluation process is to determine if a prospective foster family—

a. Meets the basic licensing requirements of ACS.

b. Is capable of providing for the needs of children placed in their care.

c. Is capable of relating to the child's family in a helpful way and assisting the foster child in relationship with its own family.

d. Is capable of working as part of a team with the ACS staff and other agencies and community resources to reach the objectives of the service plan.

9–15. Methods for conducting an evaluation

ACS will establish policies and procedures to insure that the evaluation process proceeds efficiently and achieves its purpose.

a. ACS will develop means, such as interview guides and checklists, to insure that all information needed by the family and ACS for decisions is shared.

b. ACS will make it clear that it is responsible for making the final decision regarding acceptance or nonacceptance of a family to provide foster family services. ACS is also responsible for decisions regarding placement of individual children.

c. ACS evaluation procedures will include—

(1) Interviews between the foster care coordinator and prospective foster family.

(2) On-site evaluation of physical facilities.

(3) Written documentation including family health records and foster care coordinator's plans for supervision of the foster family.

(4) References to be provided by the foster family to supplement information obtained through interviews and observations.

d. ACS will insure that the evaluation process is completed within 30 days if all required documentation, such as medical forms, is received promptly.

9–16. The formal acceptance process

ACS will establish a process that formalizes acceptance or nonacceptance for service. The final decision will be made known through a personal conference with the prospective foster family within 10 days after the study is completed. The following written materials will be available during the conference:

a. Application.

b. Other forms (health and reference).

c. Summary and evaluation of interviews.

d. Summary and evaluation of conferences and decisions.

e. Statement regarding basis for acceptance or nonacceptance for service.

f. A contract or agreement to be signed by ACS and foster parents that details the working relationships, financial plans, rights, and responsibilities of each.

g. License or certification of approval.

9–17. Criteria for selection of foster families

a. Physical requirements.

(1) The age of an individual will be considered only as it may affect the ability to care for a specific child. By itself, an individual's age may not be considered as a barrier to selection.

(2) A written statement from a physician regarding the general health and specific illnesses or disabilities of each member of the prospective foster family will be a routine part of the selection process. Each person present in the prospective foster home must submit written verification that he or she has taken a tuberculin test and has been found free of disease; other tests may be required as indicated.

(3) Physical handicaps of a member of a prospective foster family will be evaluated to determine how the person's handicaps may affect the family's ability to provide adequate care to foster children. Evaluation will include how the person's handicap may affect a child's adjustment to the foster family. Cases will be evaluated individually with the assistance of a medical consultant when indicated.

b. Factors related to income.

(1) ACS will determine that the income of a prospective foster family is stable and sufficient to maintain the family; also that reimbursement for a foster child's maintenance is not needed to meet family expenses.

(2) The intention of a prospective foster parent to maintain employment outside the home will not be considered as a barrier to selection. ACS will consider this factor when making individual placement decisions and will base the decisions solely on the best interests of the child.

c. Physical requirements of the home.

(1) Physical facilities of the home will present no hazard to the safety of the foster child.

(2) Foster homes will meet housing requirements prescribed in AR 210–50.

(3) Foster homes will be capable of providing a foster child with privacy and a comfortable environment.

(4) Each child will have his or her own bed.

(5) It is preferable that no more than two children share one sleeping room.

(6) With the exception of very young children, the sharing of sleeping rooms by children of opposite sexes is undesirable. Some foster children may be experiencing difficulties in the development of their sexual identities, attitudes, and behavior.

(7) Children, other than infants, will not share sleeping quarters with adults in the household except during emergencies.

(8) Individual space will be provided for the child's personal possessions.

(9) Adequate indoor and outdoor space for play activities will be provided.

(10) Foster family homes will be accessible to schools, recreation, churches, other community facilities, and special resources such as medical clinics.

Note: If the prospective foster family has the needed personal characteristics but the physical facilities are inadequate, ACS will help the family meet the physical facility requirements.

d. Factors related to family composition.

(1) Two-parent families will be selected in most cases. However, single-parent families will be selected when they can effectively fulfill the needs of a particular child.

(2) The presence of other children (both the foster parents' own children and foster children) and other adults (including extended family members and unrelated persons) will be considered. Their presence may affect a foster child. The effect that the presence of another child may have on current members of the home will also be evaluated.

(3) The number and the ages of children in a home (both the foster parents' own children and foster children) will be considered on an individual basis. The foster family's ability to meet the needs of all children present, the physical accommodations of the home, and the effect an additional child would have on the family as a unit is also taken into account. It is preferable that—

(*a*) A foster family care for no more than two infants under 2 years of age, including the foster parents' own children.

(*b*) A foster family have no more than a total of

six children, including foster children and their own children, in the home. (Exceptions may be made to keep siblings together.)

(c) All placement decisions include an evaluation of having some children in the foster home whose parents visit them and other foster children whose parents do not.

(d) All placement decisions include an evaluation of the effects of placing a foster child in a home where the natural children are approximately the same age and have similar needs.

e. Ability of a family to provide high quality foster parenting. The following factors will be evaluated:

(1) Commitment of all family members to the foster care process.

(2) Capacity to use good judgment in caring for children and to accept ACS supervision.

(3) Ability to accept and encourage the child's continuing relationship with his or her own family and to let go of the child when leaving the foster home.

(4) Capacity to feel and demonstrate genuine concern and affection for each child.

9–18. Periodic reassessment of foster families

The foster family will be involved in a periodic reassessment of its relationship with ACS 6 months after the family's acceptance, and each year thereafter. Reassessment will include the following:

a. Assessment of ACS and foster family's experiences in—

(1) Developing and maximizing the family's ability to meet the needs of foster children placed in the home.

(2) Helping reach the goals set for each child and the child's family.

b. A written evaluation signed by the ACS representative and the foster parents with space provided for comment by foster parents. Copies of the evaluation will be given to the foster parents and included in the foster family record.

c. When a foster home has been licensed but no placement has been made for a 6-month period, a review will be made to decide if the home will continue to be a possible resource for placement.

9–19. Termination of service of a foster family

Termination of service may occur at the request of the foster parent or ACS. Reasons for closure include child abuse or neglect, illness, financial problems, and relocation of a foster parent. ACS procedures for termination will include the following:

a. Compiling and reviewing the reasons for termination.

b. A joint conference of involved ACS representatives to determine the final decision on terminating the service of a foster home.

c. A conference in which the foster family participates.

9–20. Development of foster families

ACS will use its resources to accomplish actions shown below. Such actions will help to develop the capacities of foster families. They will also help to retain high quality foster families as resources for children and their families in need of foster family services.

a. Provide orientation and ongoing education for foster parents.

b. Provide each newly selected foster family with at least 6 hours of orientation training before a child is placed in their home.

c. Maintain an attendance record for all educational meetings.

d. Give certificates to foster parents to recognize their completion of educational programs.

e. Use experienced foster parents to lead discussion groups.

f. Advise foster parents that they must take at least 12 hours of training each year. Participation may be in ACS sponsored programs or in other community adult education programs if the foster care coordinator concurs.

g. Set up meeting time and place for ACS training programs that will be convenient for foster parents.

h. Use APF to reimburse transportation and babysitting costs. Such action will help increase participation in the programs.

9–21. Service planning

a. A service plan agreement will be developed for each child and family. All parties with a legitimate interest in the service delivery process will be actively involved in developing the service plan agreement and will sign the completed agreement. Interested parties include the foster care coordinator, the child if appropriate, and the family to the extent of their ability and desire to participate.

b. Each child and family will be given written and oral information to assure their participation as full partners in the service planning and delivery process. The information will include a description of the following:

(1) ACS policies and procedures.

(2) The service planning process and an explanation of the role that each party is expected to play throughout the planning and service delivery process.

(3) ACS and client's rights and responsibilities with respect to service planning and delivery and achievement of long-range, permanent goals.

c. An initial, written service plan will be developed within 30 days of the ACS decision to assume service responsibility. In the case of a court commitment, the plan will be developed within 30 days after the commitment date.

d. A joint conference will be held at least semiannually to review the service plan agreement and make needed changes. All the people involved in service planning and are party to a service plan agreement will attend this conference. The purpose of these conferences will be to—

(1) Review the progress that has been made toward achieving the service plan's goals for the child and family.

(2) Assess the current appropriateness and adequacy of the plan, the agreement, and the goal of service.

(3) Develop an updated plan and agreement and a revised goal, as needed.

(4) Reaffirm the agreement.

e. The service plan and agreement will be reviewed at the time of service termination at a joint ACS client conference. The meeting will determine the outcome of services, assess the service process, and determine the need, if any, for followup or postplacement support from ACS.

f. Each party to the service planning process, including the child and family, and the foster family will be provided with a copy of the initial service plan agreement and any subsequent revised plans and agreements.

g. The ACS officer will review and discuss all service plan agreements as part of supervisory conferences with the foster care coordinator.

h. Service planning agreements will include—

(1) Conditions which require ACS intervention.

(2) Resources which can be used to resolve the problem which necessitated intervention.

(3) Actions needed and taken to resolve current problems and assignment of responsibility for all actions.

(4) Evidence of change and growth.

(5) Anticipated outcomes, i.e., the goal of services.

(6) Time frames within which all activities must occur.

(7) Sample formats of service planning agreements are at figures 9–1 and 9–2.

i. Records for each child will include—

(1) Financial authorization and responsibility.

(2) Identifying information.

(*a*) DA Form 5192–R (Family Identification Sheet for a Child Receiving Service).

(*b*) DA Form 5193–R (Child's Face and Whereabouts Sheet).

(*c*) DA Form 5194–R (Child Information).

(*d*) DA Form 5195–R (Health Data).

(3) Casework activities to include—

(*a*) Referral information.

(*b*) Description of the child.

(*c*) Date and type of contacts.

(*d*) Preplacement activities.

(*e*) Placement.

j. Family records will include—

(1) ACS Parent Service Planning Agreement (fig 9–1).

(2) ACS Parent Specific Service Planning Agreement (fig 9–2).

(3) Casework activities to include—

(*a*) Date and source of referral.

(*b*) Date and type of contacts.

(*c*) Problem.

(*d*) Eligibility for foster care.

(*e*) Family background.

(*f*) Placement plans and process.

(*g*) Discussion of ACS policies and expectations.

(*h*) Any further planning.

(*i*) DA Forms 5192–R, 5193–R, 5194–R, and 5195–R will be reproduced locally on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.

I/we_____, the parents of
(Name of Parent(s))
_____ at present in
(Name of Child(ren))
foster care with _____, wish to have my/our child(ren) returned home permanently. In keeping with this wish, I/we understand and agree that I/we must participate in a program to change the following problems and behavior, which all parties agree require change prior to such a return. I/we understand that failure to comply with such a program will result in the _____ exploring alternate plans for my/our child(ren), including guardianship or adoption.

The general goals of the modification program are as follows:

1.
2.
3.
4.
5.
6.

The first stage of this agreement relates to goals _____. The specific plan for
(indicate number)
accomplishing these goals is attached. Development of plans for remaining goals depends on my/our successful completion of the first stage of the agreement. This agreement will be in effect for _____ months. The first stage of the agreement will be for _____ months: _____ to _____.

Parents:

_____ (Father)

_____ (Social Worker)

_____ (Mother)

_____ (Witness)

_____ (Date)

Figure 9–1. ACS Parent Service Planning Agreement

The _____ ACS agrees to provide the following services designed to improve accomplishment of the goals _____ stated on the ACS Parent Planning Agreement, dated _____.
(indicate number)
(Month) (Day) (Year)

1.
2.
3.
4.
5.
6.

I/We_____agree
(Name of Parent(s))
to the following activities geared to the accomplishment of the goals _____ agreed upon with the
(indicate number)
_____
(Name of Local ACS Center)

1.
2.
3.
4.
5.
6.

Visitation Schedule: The following visitation schedule has been agreed upon and will be evaluated as to its appropriateness.

Frequency _____ Place _____ Transportation _____

Parents:

_____ _____
(Father) (Social Worker)

_____ _____
(Mother) (Witness)

_____
(Date)

Figure 9–2. ACS Parent Specific Service Planning Agreement

Chapter 10
ACS Program Reports

10–1. General

In order to provide information to installation commanders and supervisors responsible for overall management of the ACS program, ACS officers will prepare an annual report on the ACS program. The report will summarize the installation ACS program and provide information on funding, staffing, programs and services, volunteers, facilities, and population served. ACS officers must insure that data is collected on an ongoing basis to support the annual report, conduct cost studies, and determine workload requirements.

10–2. ACS daily reporting system

This is an internal management reporting system designed to provide the ACS program with a daily data collection system. It enables program managers to keep an accurate and up-to-date account of services provided, manpower requirements, funding, changing program definitions, and trends in demand for services. Data collected will be used to prepare the ACS program report and other required reports.

a. DA Form 5196–R (Army Community Service Daily Worksheet) should be completed each workday and summarized monthly.

b. This worksheet is maintained as an internal document and subject to report control only as an internal document, that is, local ACS may establish an internal requirements control symbol (RCS) but no external RCS would be appropriate.

c. This report is subdivided into three areas to enable a program manager to track staff time and evaluate the installation demand for ACS services.

(1) Program Services.

(2) Administration.

(3) Training.

d. DA Form 5196–R will be reproduced locally on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.

10–3. Installation ACS Program Report (RCS AG 685(R2))

a. Installation ACS program reports will be prepared on DA Form 3063–R (Army Community Service Program Report). DA Form 3063–R will be reproduced locally on 8½- by 11-inch paper. A copy for reproduction purposes is located at the back of this regulation.

b. Reports will be prepared annually. The report will cover the period 1 October through 30 September.

c. Installation ACS program reports will be forwarded through command channels to arrive at the MACOMs not later than 30 days after the end of the reporting period.

10–4. MACOM ACS Program Summary Report (RCS AG 685(R2))

MACOM commanders will—

a. Review the installation ACS program reports and prepare a summary report on DA Form 3063–R.

b. Forward the MACOM summary report and one copy of each installation report to HQDA(DAAG–PSC), ALEX VA 22331. These reports should arrive at HQDA not later than 60 days after the end of the reporting period.

Appendix A
References

Section I
Required Publications

AR 37–100 (Account/Code Structure). Cited in paragraph 1–16.

AR 210–50 (Family Housing). Cited in paragraphs 5–5 and 9–17.

AR 340–18–9 (Maintenance and Disposition of Medical Functional Files). Cited in paragraphs 7–13 and 7–14.

AR 340–21 (The Army Privacy Program). Cited in paragraphs 4–4 and 7–3.

AR 340–21–9 (The Army Privacy Program: System Notices and Rules for Medical Functions). Cited in paragraphs 7–5 and 7–12.

AR 350–1 (Army Training). Cited in paragraph 4–3.

AR 612–10 (Reassignment Processing and Army Sponsorship and Orientation Program). Cited in paragraph 5–3.

AR 614–30 (Oversea Service). Cited in paragraph 7–17.

AR 614–200 (Selection of Enlisted Soldiers for Training and Assignment). Cited in paragraphs 7–3 and 7–17.

AR 614–203 (Assignment of Personnel with Exceptional Family Members). Cited in paragraph 8–1.

AR 635–100 (Officer Personnel). Cited in paragraph 7–20.

AR 635–200 (Enlisted Personnel). Cited in paragraphs 7–3 and 7–20.

AR 670–1 (Wear and Appearance of Army Uniforms and Insignia). Cited in paragraph 3–7.

AR 672–20 (Incentive Awards). Cited in paragraph 3–8.

AR 710–2 (Material Management for Using Units, Support Units and Installations). Cited in paragraph 3–2.

AR 930–4 (Army Emergency Relief). Cited in paragraph 4–8.

AR 930–5 (American National Red Cross Service Program and Army Utilization). Cited in paragraph 4–8.

CTA 50–909 (Field and Garrison Furnishings and Equipment). Cited in paragraph 1–17.

CTA 50–970 (Expendable/Durable Items (Except: Medical, Class V, Repair Parts and Heraldic Items)). Cited in paragraph 1–17.

DA PAM 570–551 (Staffing Guide for US Army Garrison). Cited in paragraphs 1–4 and 3–1.

DOD 4270.17M (Construction Criteria Manual). Cited in paragraph 2–2.

JTR (Joint Travel Regulation). Cited in paragraphs 1–17 and 3–5.

Section II
Related Publications*

AR 1–100 (Gifts and Donations).

AR 1–101 (Gifts for Distribution to Individuals).

AR 15–1 (Committee Management).

AR 190–24 (Armed Forces Disciplinary Control Boards and Off-Installation Military Enforcement).

AR 210–55 (Funding and Personnel Support for Morale, Welfare, and Recreational Program and Facilities).

*A related publication is merely a source of additional information. The user does not have to read it to understand this regulation.

AR 230–1	(The Nonappropriated Fund System).
AR 600–85	(Alcohol and Drug Abuse Prevention and Control Program).
AR 725–50	(Requisitioning, Receipts and Issue System).
DA PAM 600–8–10	(Management and Administrative Procedures: Assignment and Reassignment Procedures).

Appendix B
Instructions for Completing DA Form 4461–R (Family Advocacy Case Management Team (FACMT) Incident Report)

Special Instructions

Fill in all applicable blanks. If information is not known or not applicable, leave blank. Only one action can be taken on each form.

1. *To submit an initial report:*
Enter the assigned Case Number in block If.
Enter an "A" in the space for the Report Sequence Letter.
Enter "1" in block Ik.
In most cases,"1" or "2" will be entered in block Il.
Provide all other information required on the reporting form.

2. To submit a *followup* report to provide changes or additional information:
Enter the original Case Number in block If, using the next consecutive Report Sequence Letter.
Enter the date of this followup report in block Ij.
Enter a "2" in block Ik.
Provide all other information required in items Ia–k.
Enter any additional information being provided into appropriate sections.
Changes to information previously reported in blocks Il and m will be reported on followup report format.

3. To *correct* a previously submitted report:
Enter original Case Number in block If, and enter the Report Sequence Letter of the earlier report that is to be corrected. (Correction reports will not be assigned a Report Sequence Letter of their own.)
Enter an "0" in block Ik.
Enter the MTF IPDS Code in block Ie.
Enter items to be corrected in appropriate sections. (Do not provide any supplemental information on correction reports.)
Note: On items which were initially entered incorrectly but were subsequently updated by a followup report, no action need be taken to correct the earlier report.

4. To report *subsequent incidents* in an *open case*:
Enter the original Case Number in block If, using the next consecutive Report Sequence Letter.
Enter the date of the new incident in block Ii.
Enter a "5" in block Ik.
Provide all other information required on the reporting form.

5. To *report* a *closed case*:
Enter the original Case Number in block If, using the next consecutive Report Sequence Letter.
Enter a "7" in block Ik.
Provide all other information required on the reporting form.

6. To *transfer* out a case:
Enter the original Case Number in block If, using the next consecutive Report Sequence Letter
Enter a "4" in block Ik and specify where transferred.
Provide all other information required in items Ia–k.
In section XII, provide a brief description of transfer actions to include the MTF Code of the receiving MTF and the name of the FACMT member contacted at the receiving MTF.

7. To *transfer* a case from another installation, the gaining FACMT will submit a report containing, as a minimum, the following information:
Assign a new local Case Number in block If. Enter an "A" in the space for the Report Sequence Letter.
Enter a "3" in block Ik.
Provide all other information required in items Ia–k.
Provide a brief description of the new treatment plan in Section XII.

8. To *close* a case:
Enter the original case number in block If, using the next consecutive
Report Sequence Letter.
Provide all other information required in items Ia–k.
Enter a "6" in block Ik.
In cases being closed because suspected abuse was determined to be unfounded, also enter a "3" in block Il.
Enter descriptive comments in Section XII, on all case closures to include update of case history and prognosis. Do not complete descriptive comments on those determined to be unfounded.

General Instructions

Section I—General Information

a. Enter Social Security Number (SSN) of official sponsor of the maltreated (whether sponsor is alive or deceased).

b. Enter c for Child Abuse or Neglect and s for Spouse Abuse.

c. Enter the name of the Medical Treatment Facility (MTF).

d. Enter the appropriate code for the MACOM under which the installation MTF is organized.

e. Enter the MTF code number. Obtain the code number from MTF Patient Administration Division.

f. Each installation FACMT will maintain its own case identification system, will assign a unique case number to each case (child or spouse), and will submit all reports relative to that specific child or spouse under the same basic case number. The case number is composed of two elements.

1. FY—Enter the last two digits of the fiscal year (82) in which the initial Case Management Incident Report is completed. (Once designated as part of a Case Number, this two-digit number will not change even though the fiscal year changes).

2. Sequence Number—This is a three-digit number used to distinguish between cases. Numbering of new cases will begin anew on the first day of each new fiscal year; assignment will be made in consecutive sequence (e.g., 001, 002, 003, etc.). Each child or spouse is considered a new case and will be assigned a different sequence number.

In addition, a Report Sequence Letter will be assigned, in consecutive sequence (e.g., A, B, C, etc.) to each report submitted on a specific case. This sequencing will carry over from 1 fiscal year to another.

Example: Suspected incident occurs on 20 September 1981, the Case Management Incident Report is completed on 2 October 1981 (FY 82). It is the third case reported from the MTF in the new fiscal year and it is the initial report submitted on the case. The Case Number and Report Sequence Letter to be assigned is *82003 A*. Three subsequent reports (B, C, & D) are submitted on the case in FY 82. The case is to be closed by a report completed on 3 January 1983; the Case Number and Report Sequence Letter of the final report will read *82003 E*.

g. Chairperson of the FACMT.

h. Self-explanatory.

i. Enter digits for the day/month/year (e.g., 3 June 1981 – 03 06 82).

j. Enter today's date.

k. Enter codes per Special Instructions above.

l. Enter the code for appropriate case determination. Case determinations include:

(1) *Suspected.* Abuse may or may not have occurred and insufficient evidence exists to warrant a determination of established abuse.

(2) *Established.* After thorough investigation and evaluation the evidence in a particular case substantiates the belief that abuse did occur.

(3) *Unfounded.* After appropriate investigation, a determination has been made that the evidence in a particular case is insufficient to support any suspicion that abuse or neglect did occur.

m. Self-explanatory.

n. Self-explanatory.

o. Self-explanatory.

p. Self-explanatory.

Section II—Child Identification Data

a. Enter the first four letters of child's first name in boxes 43 through 46.

b. Self-explanatory.

c. Self-explanatory.

d. Self-explanatory.

e. Self-explanatory.

f. Enter the birth order of the child, the code for a preadoptive child, or 00 for all others.

g. Enter the appropriate code from the relationship categories listed in Section XIc. If more than one person has maltreated the child, enter additional relationship codes in boxes 63 and 64.

h. Enter location of domicile of child when normally residing with family or legal guardian at the time abuse occurred. Military housing is DOD housing on DOD controlled property; civilian housing is housing located in the civilian community including military leased housing.

Section III—Spouse Identification Data

a. Enter the first four letters of spouse's first name in boxes 66 through 69.

b. Self-explanatory.

c. Self-explanatory.

d. Self-explanatory.

e. Self-explanatory.

f. Enter the principal residence of the spouse. Military housing is DOD housing on DOD controlled property; civilian housing is housing located in the civilian community including military leased housing.

g. Self-explanatory.

h. Self-explanatory.

i. Self-explanatory.

j. Self-explanatory

k. Self-explanatory.

Section IV-Alcohol and Drug Related

a. Self-explanatory.

b. Self-explanatory

Section V—Sponsor Identification Data

a. Self-explanatory.

b. Self-explanatory.

c. Self-explanatory.

d. See reference codes, section *XI*b, for ethnic groups.

e. Self-explanatory.

f. Enter appropriate grade code. For all general officers enter GO and for civilians enter 31.

g. Self-explanatory.

h. Self-explanatory.

Section VI—Identification Data on Maltreater

a. Enter SSN of maltreater if one exists and is obtainable, if not enter zeros.

b. Self-explanatory.

c. Self-explanatory.

d. Self-explanatory.

e. Self-explanatory.

f. Self-explanatory.

g. Self-explanatory.

h. Self-explanatory.

i. Self-explanatory.

j. Self-explanatory.

k. Self-explanatory.

Section VII—Identification Data on Second Maltreater

Complete only if second maltreater is identified.

Section VIII—Medical Condition Diagnosed Related to Incident

Use the International Classification of Diseases, adapted for use in the United States (ICD–9), Revised 1975, Volumes I and II. List in order of severity.

Section IX—Stress Factors Present

List in order of severity the most significant stress factors that precipitated the maltreatment.

Section X—Service Provided to Individual or Family

List in the order of priority the major services by military and/or civilian agencies.

Section XI—Reference Codes

Reference codes only.

Section XII—Descriptive Statement

Provide complete and concise information on the incident, results of medical examination, treatment plan, response of family to treatment, considerations for future protection of the child or spouse, etc. Include information that would be of direct benefit to other FACMT who might be working with the family in the future. Provide a periodic update of descriptive information.

Family Advocacy Case Management Team Incident Reports will be prepared and signed by the chairperson of the FACMT or an officially designated representative.

Appendix C
Numerical Listing of Prescribed and Referenced Forms

This regulation prescribes the following forms: DA Forms 3063–R, 4162–R, 4461–R, 4172–R, 4720–R, 4723–R, 4723–1–R, 4723–2–R, 5184–R, 5185–R, 5186–R, 5187–R, 5188–R, 5189–R, 5190–R, 5191–R, 5192–R, 5193–R, 5194–R, 5195–R, and 5196–R; SF 600; and PS Form 3811.

The following forms are available through normal publication supply channels, except for those that are reproduced locally or obtained from other agencies according to instructions in this regulation;

Section I
Department of the Army Forms

DA Form	*Title*	*Chapter*
3063–R	Army Community Service Program Report	7, 10
4162–R	Army Community Service Volunteer Service Record	3
4461–R	Family Advocacy Case Management Team (FACMT) Incident Report	7
4712–R	Volunteer Agreement	3
4713–R	Army Community Services Volunteer Daily Time Record	3
4720–R	Army Community Service Installation Fact Sheet	5
4723–R	Report of Special Education Services for the Exception Family Member	8
4723–1–R	Report of Health-Related Services for the Exceptional Family Member	8
4723–2–R	Health-Related Survey-Individual Facility Report	8
5184–R	Consumer Complaint	4
5185–R	Agency Followup	6
5186–R	Client Inquiry and Disposition Data	6
5187–R	Application for Respite Caregivers	8
5188–R	Medical Report on Applicant for Certification to Provide Care for Handicapped Children or Adults	8
5189–R	Application for Respite Care for Handicapped Children and Adults	8
5190–R	Clinician's Information	8
5191–R	Information on Handicapped Individual	8
5192–R	Family Identification Sheet for a Child Receiving Service	9
5193–R	Child's Face and Whereabouts Sheet	9
5194–R	Child Information	9

DA Form	*Title*	*Chapter*
5195–R	Health Data	9
5196–R	Army Community Service Daily Worksheet	10

Section II
Miscellaneous Forms

PS Form 3811	Return Receipt	7
SF 600	Chronological Record of Medical Care	7

DEFINITIONS OF HANDICAPPING CATEGORIES FOR COMPLETING DA FORM 4723-R

• HANDICAPPING CATEGORY:

1. *Generic, Mild Educational Impairment* — A noncategorical approach to educating learning disabled, mildly retarded, and mildly behaviorally disordered students providing special education in a generic resource program. Psychoeducational similarities of students with mild educational impairments is conducive to the programmatic considerations for their special education needs. Programs offered are of a resource nature and do not include students who require more than 20% of their school day in a special education program.

2. *Deaf* — A hearing loss or deficit so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, to the extent that his or her educational performance is adversely affected.

3. *Deaf/Blind* — Concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that they cannot be accommodated in special education programs solely for deaf or blind children.

4. *Hard of Hearing* — A hearing impairment, whether permanent or fluctuating, that adversely affects a child's educational performance but that does not constitute deafness.

5 & 6. *Mentally Retarded (Mild, Educational and Severely Handicapped)* — Significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a child's educational performance.

7. *Multihandicapped* — Concomitant impairments (such as mentally retarded-blind or mentally retarded—orthopedically impaired), the combination of which causes such severe educational problems that they cannot be accommodated in special educational programs solely for one of the impairments.

8. *Orthopedically Impaired* — A severe orthopedic impairment that adversely affects a child's educational performance. The term includes congenital impairments (such as clubfoot and absence of some member), impairments caused by disease (such as poliomyelitis and bone tuberculosis) and impairments from other causes (such as cerebral palsy, amputations, and fractures or burns causing contractures).

9. *Other Health Impaired* — Limited strength, vitality, or alertness due to chronic or acute health problems that adversely affect a child's educational performance, including heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle-cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, diabetes, or autism.

10. *Seriously Emotionally Disturbed* — A condition that has been confirmed by clinical evaluation and diagnosis and that, over a long period of time and to a marked degree, adversely affects educational performance, and that exhibits one or more of the following characteristics:

(1) An inability to learn that cannot be explained by intellectual, sensory, or health factors.

(2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(3) Inappropriate types of behavior under normal circumstances.

(4) A tendency to develop physical symptoms or fears associated with personal or school problems.

(5) A general pervasive mood of unhappiness or depression.

The term includes children who are schizophrenic, but does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.

11. *Special Learning Disability* — A disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language that may manifest itself as an imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain disfunction, dyslexia, and developmental aphasia. The term does not include children who have learning problems that are primarily the result of visual, hearing, or motor handicaps, mental retardation, emotional disturbance, or environmental, cultural, or economic differences.

12. *Speech Impaired* — A communication disorder, such as stuttering, impaired articulation, language impairment, or a voice impairment, that adversely affects a child's educational performance.

13. *Visually Handicapped/Blind* — A visual impairment that, even with correction, adversely affects a child's educational performance. The term includes both partially seeing and blind children.

14. *Preschool Handicapped* — Youngsters between the ages of 3 and 5 with handicaps and/or significant developmental delays who are entitled to receive special educational and/or related services through the non-categorical preschool programs for exceptional children. Children whose third or fifth birthday falls before December 31 meet the age requirement for fall enrollment. The developmental delays and/or handicapping conditions may occur in one or more of the following areas:

(1) Gross Motor
(2) Fine Motor
(3) Perceptual Development
(4) Language/Speech
(5) Cognitive Development
(6) Social/Emotional
(7) Sensory Impairment
(8) Physical Handicap

DEFINITIONS FOR DA FORM 4723-2-R
HEALTH-RELATED SURVEY
INDIVIDUAL FACILITY REPORT

DEFINITIONS:
FUNCTIONAL CATEGORIES

	LEVEL A	LEVEL B	LEVEL C	LEVEL D
High Risk Newborn *(less than 18 months of age)*	Follow-up by pediatric physical therapist *(PT)* and developmental pediatrician at regular intervals *(every 2 - 4 months)* during the first 18 months of life.	Follow-up by pediatric physical therapist *(PT)*/ occupational therapist *(OT)* and developmental pediatrician at frequent intervals *(every month during the first 18 months of life).*	An abnormality of movement and tone exist. PT/OT follow-up and therapy once or twice a week is indicated. Access to medical center *(MEDCEN)* multidisciplinary team evaluations as needed.	
Delayed Early Development *(under 6 years of age)*	Suspicion or at risk for developmental delay. Requires a 1 - 6 month evaluation by PT, speech therapist and developmental pediatrician.	Developmental delay has been diagnosed with early cognitive enrichment recommended *(public school or community based).*	Developmental delay diagnosed with OT/PT recommended.	Developmental delay is diagnosed with early cognitive enrichment *(public school or community based)* and physical/ occupational therapy recommended.
Mental Retardation *(over 6 years of age)*	Requires consultation with general pediatrician or family practice annually or semiannually *(aside from acute or chronic medical illness).*	Requires frequent pediatric or family practice follow-up for social, school and family issues as well as acute or chronic medical illness.	Requires proximity to MEDCEN because of complexity of medical causes of mental retardation *(i.e., PKU, hydrocephalus).* Full multidisciplinary team involvement is necessary.	Requires residential care.
Oral Motor Deficits	Speaking and eating are possible but not optimal. One hour per week of oral motor therapy *(PT, OT, or Speech Therapist)* is recommended as a short-term adjunct to regular therapy program; consultation by oral motor therapist to speech pathologist or NDT physical therapist thereafter.	Oral motor dyspraxia prevents a normal acquisition of language and feeding. Requires individual oral motor therapy 1 to 2 hours per week as long-term treatment.	Oral motor skills are so poor that tube feeding is recommended. Oral motor therapy required daily as part of initial rehabilitation program. Oral motor therapy may be phased into consultation only if reasonable progress is not made.	
Restricted Mobility	Functional ambulator, with minor neuromuscular deficits, limited community ambulator or part-time wheelchair user. Pediatric PT 1-2 hours per week. Can overcome common *architectural barriers.* May require a 6 month reevaluation by physiatrist, pediatrician, neurologist or orthopedist.	Independent in wheelchair use. Requires PT 1-2 hours per week or less. May require 6 month reevaluation by physiatrist, pediatrician, neurologist, or orthopedist. Must eliminate *architectural barriers.*	Partially dependent in wheehchair ambulation. PT 1-2 hours per week *(approximately).* Must eliminate architectural barriers.	Totally dependent in mobility. PT maintenance, supervision, or therapy.

FUNCTIONAL CATEGORIES	LEVEL A	LEVEL B	LEVEL C	LEVEL D
Activities of Daily Living *(dressing, bathing, eating)*	Infrequent consultation by OT/PT to parents, school, or patient to improve or maintain skills.	Frequent therapy indicated initially *(once or twice a week)* with a decrease in frequency of services anticipated after 6 months or as skills are mastered by patient.	Respite and residential care are reasonable possibilities.	
Sensory-Integration *(educational aspects to include balance and equilibrium dyspraxia, and tactile defensiveness)*	Sensory-integration problems interfere with school performance to a modest extent so that educational OT consult to teacher, or weekly group OT, or monitored home program with sensory-integration orientation is indicated. Initial or annual multidisciplinary team reevaluation is indicated.	Sensory-integration problems interfere significantly with school performance such that individual sensory-integration therapy 1 or 2 hours per week is indicated. Annual multidisciplinary team reevaluation is indicated.	Sensory-integration problems completely preclude participation in regular classroom activities. Requires individual therapy or very frequent supervision by OT.	
Adaptive Equipment *(such as crutches, braces, splints special feeding and dressing utensils, prostheses)*	Requires adaptive devices routinely available through Medical Treatment Facility (MTF). Requires periodic adjustments.	Requires adaptive equipment not routinely available but can be ordered by staff at MTF with periodic adjustment. Requires PT/OT, brace shop and consultation with physiatrist and/or orthopedist.	Requires specially designed and fitted equipment with special fabrication skills, or condition is changing so routine visits to physiatrist, orthopedist, and brace shop may be needed. May require weekly - daily OT/PT to use equipment *(temporarily)*.	Multiple special equipment needs available at MEDCEN only.
Speech/Language Deficit *(any age)*	Managed by Speech/ Language Pathologist in conjunction with parents. Occasional therapy, generally consultation basis.	Initial management on weekly basis *(probably short-term with occasional rechecks after that)*. May be adjunct to early cognitive enrichment program.	Requires regular therapy on at least a weekly basis as long-term therapy plan. *(Does not include signing)*.	Requires a program that include signing.
Hard of Hearing and Deaf*(earmold fabrication, hearing aids)*	Requires follow-up audiogram or auditory perceptual testing. Can be managed by pediatrician/family practice.	No type of prosthetic device necessary. May require preferential seating in school. Proximity to health care facility for audiology and ENT consult as needed.	Requires hearing aids and earmold fabrication as necessary. Therapy for articulation, language disorders, and/or signing necessary.	Requires regular evaluation, treatment, or surgery by pediatric ENT specialist and evaluation by multidisciplinary team.
Vision	Visual problems requiring routine consultations/ examinations on an annual basis.	Visual impairment requiring evaluation by multidisciplinary team and possibly infrequent follow-up or surgery by ophthalmologist. *(Albino; CP with Strabismus)*.	Requires ongoing care by ophthalmologist. *(Glaucoma, Retinitis, Cataracts, Post Trauma)*.	Requires MEDCEN with multidisciplinary team *(Developmental Optometrist/Pediatric Ophthalmologist)*.
Bladder/Bowel Incontinence *(not emotional)*	Can be managed by general pediatrician/ family practice with consult to urology or general surgery as needed.	Requires special education in techniques such as intermittent catheterization or bowel training usually found only in hospital with multidisciplinary teams which include a community health nurse.	Requires repeated special tests *(IVP, urodynamics, sphincter EMGs)*.	

FUNCTIONAL CATEGORIES	LEVEL A	LEVEL B	LEVEL C	LEVEL D
Stoma *(airway, stomach, bladder, bowel)*	Requires proximity to general hospital with pediatrician/family practice and the appropriate surgical specialist.	Requires close supervision by health nurse as well as pediatrician and surgeon.	The child should be located near a MEDCEN for frequent medical and surgical support and health nurse involvement.	
Behavioral and Emotional Disorders *(including but not limited to anxiety, attention deficit disorder, functional encopresis and enuresis, oppositional and conduct disorders, stereotyped movement disorders, phobic disorders, affective disorders such as depression, schizophrenia, psychosis, pervasive developmental disorder such as autism, eating disorder such as anorexia nervosa)*	Pediatrician/family practice can manage alone or with occasional consult to child psychogist or child psychiatrist.	Evaluation and management by child psychologist or child psychiatrist for short-term intervention and referral back to pediatrician/family practice.	Long-term outpatient therapy by child psychologist/child psychiatrist and may need occasional short-term hospitalization.	Residential or prolonged inpatient care.
Learning Problems *(related to attention deficit disorder (ADD), learning disability (LD), underachievers, possible or diagnosed mental retardation)*	Requires testing and evaluation by child psychologist as initial evaluation and/or minimum of every 3 years.	Requires testing and evaluation by child psychologist as initial evaluation and/or every year.	Child psychologist with background in educational psychology is needed for testing and ongoing monitoring of classroom performance.	Requires neuropsychiatry evaluation.
Medical–Social Work Services *(respite care, temporary or permanent foster care, handling possible child abuse cases, parenting classes, group therapy)*	Probably can be managed by general pediatrician alone with occasional consultation to social work.	Services of social work clinic will be necessary on a regular basis.	Intensive social work intervention is likely.	
Family therapy *(through social work, child guidance, or multidisciplinary team)*	Family therapy is indicated.	Family therapy is indicated with crisis intervention likely.		
Functional Disabilities *(secondary to other chronic medical conditions such as asthma, diabetes, cystic fibrosis, juvenile rheumatoid arthritis, heart disease, etc.)*	Can be managed by a general medical officer.	Requires close proximity to a hospital and pediatrician.	Requires care of specialists normally found at medical centers.	Requires resources of a major medical center and multidisciplinary team in pediatric rehabilitation.

HEALTH-RELATED SURVEY – INDIVIDUAL FACILITY REPORT

For use of this form, see AR 608-1; the proponent agency is TAGO.

OMB APPROVED NO. 0704-0175

This form will be completed by each individual facility, indicating both the capabilities of the facilities and individual providers used by the facility. Use typewriter or print legibly in ink. NOTE: Read the definitions attached to this form before making each entry.

SECTION I – GENERAL INFORMATION

1. NAME OF FACILITY	2. ADDRESS	3. CHIEF ADMINISTRATOR
4. BUSINESS TELEPHONE	**5. SERVICE HOURS** *(DAYS/HOURS)*	**6. AREA SERVED**

7. TYPE OF OWNERSHIP *(Indicate the category which best describes the legal ownership of this facility.)* *(Check one box only)*

☐ Private - for Profit ☐ Private - not for Profit
☐ Local Government ☐ State Government ☐ Federal Government
☐ Other *(Specify)*:

8. ACCESSIBILITY

a. **TRANSPORTATION** *(Check all that applies and fill in blanks)*

☐ On bus line ☐ Not on bus line; distance to bus line is: _____ blocks; _____ miles
☐ Parking available ☐ Parking Fee $ _____
☐ Taxi stand at facility ☐ Facility operates own transportation system

b. **WHEELCHAIR ACCESS** *(Check all that applies)* ☐ Building ☐ Restrooms

9. FEE FOR SERVICE *(Check all that applies)*

☐ Full Fee ☐ No Fee ☐ Sliding Scale
☐ Advance Pay ☐ Medicaid ☐ CHAMPUS
☐ Private Health Insurance ☐ Other

☐ Unrestricted
☐ Restricted *(Specify age groups)*: _____

SECTION II – FUNCTIONAL CATEGORIES SERVED

NOTE: Indicate below the capability of your facility to provide health-related services to children in each category; and whether or not your facility has vacancies for new patients during the next six months.

LINE	FUNCTIONAL CATEGORY	LEVEL A				LEVEL B				LEVEL C				LEVEL D			
		SERVICE PROVIDED		FUTURE CAPABILITY 1/		SERVICE PROVIDED		FUTURE CAPABILITY 1/		SERVICE PROVIDED		FUTURE CAPABILITY 1/		SERVICE PROVIDED		FUTURE CAPABILITY 1/	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
1	High Risk Newborn *(less than 18 months old)*																
2	Delayed Early Development *(under 6 yrs of age)*																
3	Mental Retardation *(over 6 yrs of age)*																
4	Oral Motor Deficits																
5	Restricted Mobility																
6	Activities of Daily Living *(dressing, bathing, eating)*																
7	Sensory - Integration 2/																
8	Adaptive Equipment 3/																
9	Speech/Language Deficit *(any age)*																
10	Hard of Hearing and Deaf 4/																

1/ *In terms of vacancies during the next six months.*
2/ *Educational aspects to include balance and equilibrium dyspraxia, and tactile defensiveness.*
3/ *Includes crutches, braces, splints, special feeding and dressing utensils, prostheses.*
4/ *Includes earmold fabrication and hearing aids.*

LINE	FUNCTIONAL CATEGORY	LEVEL A				LEVEL B				LEVEL C				LEVEL D			
		SERVICE PROVIDED		FUTURE CAPABILITY 1/		SERVICE PROVIDED		FUTURE CAPABILITY 1/		SERVICE PROVIDED		FUTURE CAPABILITY 1/		SERVICE PROVIDED		FUTURE CAPABILITY 1/	
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
11	Vision																
12	Bladder/Bowel Incontinence *(not emotional)*																
13	Stoma *(airway, stomach, bladder, bowel)*																
14	Behavioral and Emotional Disorders 5/																
15	Learning Problems 6/																
16	Medical - Social Work Services 7/																
17	Family Therapy 8/																
18	Functional Disabilities 9/																

SECTION III – SPECIALTIES AND SUBSPECIALTIES

Indicate the capability of your facility to provide health-related services to children in the categories shown below.

	CATEGORY	YES	NO		CATEGORY	YES	NO		CATEGORY	YES	NO
1	Audiology			12	Orthopedic Surgery			22	Pediatric Physiatry		
2	Cardiology			13	Pediatric Adolescent Medicine			23	Pediatric Pulmonary Diseases		
3	Community Health Nursing			14	Pediatric Cardiology			24	Physiatry		
4	ENT Surgery			15	Pediatric Development/ Behavioral Medicine			25	Plastic Surgery		
5	General Surgery			16	Pediatric Endocrinology			26	Psychiatry		
6	Genetics			17	Pediatric Gastroenterology			27	Psychology		
7	Neurology			18	Pediatric Hematology /Oncology			28	Rheumatology		
8	Neurosurgery			19	Pediatric Infectious Diseases			29	Social Work		
9	Ophthalmology			20	Pediatric Nephrology			30	Thoracic Surgery		
10	Ophthalmology, Pediatric			21	Pediatric Neurology			31	Urology		
11	Ophtalmology, Retina Specialist										

5/ *Includes but it is not limited to anxiety, attention deficit disorder functional encopresis and enuresis, oppositional and conduct disorders, stereotyped movement disorders, phobic disorders, affective disorders such as depression, schizophrenia, psychosis, pervasive developmental disorder such as autism, eating disorder such as anorexia nervosa.*

6/ *Related to ADD, LD, underachievers, possible or diagnosed mental retardation.*

7/ *Includes respite care, temporary or permanent foster care, handling possible child abuse cases, parenting classes, group therapy.*

8/ *Conducted through social work child guidance, or multidisciplinary team.*

9/ *Secondary to other chronic medical conditions such as asthma, diabetes, cystic fibrosis, juvenile rheumatoid arthritis, heart disease, etc.*

REPORT OF SPECIAL EDUCATION SERVICES FOR THE EXCEPTIONAL FAMILY MEMBER

For use of this form, see AR 608-1; the proponent agency is TAGO.

DATE OF REPORT

REQUIREMENT CONTROL SYMBOL AG-884

SCHOOL NAME	NO. OF MILES FROM INSTAL.	THRU: *(Include ZIP Code)*	TO:	FROM: *(Include ZIP Code)*
			HQDA (DAAG-PSC) ALEXANDRIA, VA 22331	

LINE ITEMS	CATEGORY OF HANDICAPPED SERVED	TYPES OF SPECIAL EDUCATION PLACEMENTS *(Check one or more for each category of handicapped served)*			GRADE LEVEL SERVED *(Check one or more for each category of handicapped served)*					
		RESIDENTIAL INSTITUTION	SPECIAL DAY SCHOOL	EARLY CHILDHOOD PRESCHOOL PROGRAM	PRESCHOOL	KINDERGARTEN	PRIMARY *(1-3)*	INTERMEDIATE *(4-6)*	JR. HIGH *(7-8)*	HIGH SCHOOL *(9-12)*
	a	*b*	*c*	*d*	*e*	*f*	*g*	*h*	*i*	*j*
1	Generic, Mild Educational Impairment									
2	Deaf									
3	Deaf/Blind									
4	Hard of Hearing									
5	Mentally Retarded *(mild, educational)*									
6	Mentally Retarded *(severely handicapped)*									
7	Multihandicapped									
8	Orthopedically Impaired									
9	Other Health Impaired									
10	Seriously Emotionally Disturbed									
11	Specific Learning Disability									
12	Speech Impaired									
13	Visually Handicapped/ Blind									
14	Preschool Handicapped									

TYPED NAME OF INDIVIDUAL PREPARING REPORT	SIGNATURE	COMMERCIAL TEL. NO.	AUTOVON NO.

CONTINUE ACROSS BY LINE NUMBER

SPECIALTIES AND SUBSPECIALTIES

(Indicate with a checkmark if support is available. Leave blank if support is not available.)

LINE NUMBER	AUDIOLOGY *u*	CARDIOLOGY *v*	COMMUNITY HEALTH NURSING *w*	ENT SURGERY *x*	GENERAL SURGERY *y*	GENETICS *z*	NEUROLOGY *aa*	NEUROSURGERY *bb*	OPHTHALMOLOGY *cc*	OPHTHALMOLOGY, PEDIATRIC *dd*	OPHTHALMOLOGY, RETINA SPECIALIST *ee*	ORTHOPEDIC SURGERY *ff*	PEDIATRIC ADOLESCENT MEDICINE *gg*	PEDIATRIC CARDIOLOGY *hh*	PEDIATRIC DEVELOP./ BEHAVIORAL MEDICINE *ii*	PEDIATRIC ENDOCRINOLOGY *jj*	PEDIATRIC GASTROENTEROLOGY *kk*	PEDIATRIC HEMATOLOGY/ ONCOLOGY *ll*	PEDIATRIC INFECTIOUS DISEASES *mm*	PEDIATRIC NEPHROLOGY *nn*	PEDIATRIC NEUROLOGY *oo*	PEDIATRIC PHYSIATRY *pp*	PEDIATRIC PULMONARY DISEASES *qq*	PHYSIATRY *rr*	PLASTIC SURGERY *ss*	PSYCHIATRY *tt*	PSYCHOLOGY *uu*	RHEUMATOLOGY *vv*	SOCIAL WORK *ww*	THORACIC SURGERY *xx*	UROLOGY *yy*
1																															
2																															
3																															
4																															
5																															
6																															

TYPED NAME OF INDIVIDUAL PREPARING REPORT	SIGNATURE	COMMERCIAL TEL. NO.	AUTOVON

REPORT OF HEALTH-RELATED SERVICES FOR THE EXCEPTIONAL FAMILY MEMBER

For use of this form, see AR 608-1; the proponent agency is TAGO.

DATE OF REPORT

REQUIREMENT CONTROL SYMBOL AG-884

THRU: *(Include ZIP Code)*

TO:
HQDA (DAAG-PSC)
ALEXANDRIA, VA 22331

FROM: *(Name of Installation) (Include ZIP Code)*

LINE NUMBER	NAME OF FACILITY *(Name of facility will be entered only on the face of this form. Continue across on reverse by line number.)*	APPROXIMATE NO. OF MILES FROM INSTAL.	LEVELS	CARE RELATED TO FUNCTIONAL CATEGORIES*																
				HIGH RISK NEWBORN	DELAYED EARLY DEVELOPMENT	MENTAL RETARDATION	ORAL MOTOR DEFICITS	RESTRICTED MOBILITY	ACTIVITIES OF DAILY LIVING	SENSORY INTEGRATION	ADAPTIVE EQUIPMENT	SPEECH/LANGUAGE DEFICIT	HARD OF HEARING AND DEAF	VISION	BLADDER/BOWEL INCONTINENCE	STOMA	BEHAVIORAL AND EMOTIONAL DISOR.	LEARNING PROBLEMS	MEDICAL SOCIAL WORK SERVICES	FAMILY THERAPY	FUNCTIONAL DISABILITIES
	a	*b*		*c*	*d*	*e*	*f*	*g*	*h*	*i*	*j*	*k*	*l*	*m*	*n*	*o*	*p*	*q*	*r*	*s*	*t*
1			A																		
			B																		
			C																		
			D																		
2			A																		
			B																		
			C																		
			D																		
3			A																		
			B																		
			C																		
			D																		
4			A																		
			B																		
			C																		
			D																		
5			A																		
			B																		
			C																		
			D																		
6	**RECAPITULATION**		A																		
			B																		
			C																		
			D																		

**Enter in the designated line(s) the letter(s) corresponding to the level(s) of care (service) the facility can provide, but only if service can also be provided in the future. Do not enter anything if service cannot be provided as stated.*

PART I - PROGRAM SERVICES *(Cont'd)*

SERVICES PROVIDED	TOTAL POPULATION CHARACTERISTICS																		TOTAL NUMBER SERVED	TIME SPENT
C. INFORMATION/REFERRAL/ FOLLOW-UP	E1 - E4		E5 - E6		E7 - E9		W01 - W04		01 - 03		04 - 04		GO		RETIREE		CIV			
	SVC SVC	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	RET	FAM MBR	CIV MBR	FAM MBR		
1. INTAKE SERVICE																				
a. TELEPHONE CONTACTS																				
b. PERSONAL INTERVIEWS																				
c. MAIL																				
2. PUBLIC AWARENESS																				
a. BRIEFING																				
b. TV *(Interviews or Announcements)*																				
c. RADIO *(Interviews or Announcements)*																				
d. WELCOME PACKETS/FACT SHEETS																				
e. ACS BULLETIN																				
3. REFERRAL																				
a. OTHER ACS COMPONENTS																				
b. MILITARY AGENCIES																				
c. OUTSIDE CIVILIAN AGENCIES																				
4. FOLLOW-UP																				
a. CLIENT																				
b. OTHER AGENCIES																				
c. UNIT																				

PART I - PROGRAM SERVICES *(Cont'd)*

SERVICES PROVIDED	TOTAL POPULATION CHARACTERISTICS																		TOTAL NUMBER SERVED	TIME SPENT
D. EXCEPTIONAL FAMILY MEMBER PROGRAM	E1 - E4		E5 - E6		E7 - E9		W01 - W04		01 - 03		04 - 06		GO		RETIREE		CIV			
	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	RET	FAM MBR	CIV MBR	FAM MBR		
1. INFORMATION/REFERRAL																				
2. SUMMER DAY CAMP																				
3. RECREATIONAL PROGRAM																				
4. RESPITE CARE																				
5. SEMINAR/GROUP DISCUSSIONS																				
6. FACT SHEETS																				
7. RESOURCE DIRECTORIES																				
8. NEWSLETTERS																				

PART I - PROGRAM SERVICES *(Cont'd)*																						
SERVICES PROVIDED	TOTAL POPULATION CHARACTERISTICS																					
E. FAMILY ADVOCACY	E1 - E4		E5 - E6		E7 - E9		W01 - W04		01 - 03		04 - 06		GO		RETIREE		CIV		TOTAL NUMBER SERVED	TIME SPENT
	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	RET	FAM MBR	CIV MBR	FAM MBR		
1. CHILD ABUSE/NEGLECT																				
a. PHYSICAL ABUSE																				
(1) SUSPECTED																				
(2) ESTABLISHED																				
(3) UNFOUNDED																				
b. SEXUAL ABUSE																				
(1) SUSPECTED																				
(2) ESTABLISHED																				
(3) UNFOUNDED																				
c. NEGLECT																				
(1) SUSPECTED																				
(2) ESTABLISHED																				
(3) UNFOUNDED																				
d. DEATH																				

PART I - PROGRAM SERVICES *(Cont'd)*

SERVICES PROVIDED	TOTAL POPULATION CHARACTERISTICS																		TOTAL NUMBER SERVED	TIME SPENT
	E1 - E4		E5 - E6		E7 - E9		W01 - W04		01 - 03		04 - 06		GO		RETIREE		CIV			
E. FAMILY ADVOCACY	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	RET	FAM MBR	CIV MBR	FAM MBR		
2. SPOUSE ABUSE																				
a. SUSPECTED																				
b. ESTABLISHED																				
c. UNFOUNDED																				
d. DEATH																				
3. EMERGENCY HOUSING																				
a. CHILD CARE																				
b. SHELTER																				
(1) ACS SHELTER																				
(2) CIVILIAN (CIV) SHELTER																				
4. COUNSELING *(Family and Individual)*																				
a. INDIVIDUAL																				
b. COUPLE																				
c. FAMILY																				
d. PARENT-CHILD																				
e. GROUP																				

PART I - PROGRAM SERVICES *(Cont'd)*																				
SERVICES PROVIDED	TOTAL POPULATION CHARACTERISTICS																			
	E1 - E4		E5 - E6		E7 - E9		W01 - W04		01 - 03		04 - 06		GO		RETIREE		CIV		TOTAL NUMBER SERVED	TIME SPENT
E. FAMILY ADVOCACY	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	RET	FAM MBR	CIV MBR	FAM MBR		
5. REFERRAL																				
a. FACMT																				
b. MTF																				
c. OUTSIDE CIV AGENCIES																				
d. CID																				
e. MP																				
f. CIV POLICE																				
6. PUBLIC AWARENESS																				
a. BRIEFING																				
b. FACT SHEETS																				
7. CRISIS HOTLINE SERVICE																				
a. CHILD ABUSE/NEGLECT																				
b. SPOUSE ABUSE																				
8. PREVENTATIVE SERVICES																				
9. OTHER SUPPORT SERVICES																				

PART I - PROGRAM SERVICES *(Cont'd)*																				
SERVICES PROVIDED	POPULATION CHARACTERISTICS																		TOTAL NUMBER SERVED	TIME SPENT
	E1 - E4		E5 - E6		E7 - E9		W01 - W04		01 - 03		04 - 06		GO		RETIREE		CIV			
F. CONSUMER AFFAIRS	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	RET	FAM MBR	CIV MBR	FAM MBR		
1. BUDGET EDUCATION/INFORMATION																				
2. FINANCIAL COUNSELING																				
3. DEBT LIQUIDATION SERVICE																				
a. NUMBER OF PERSONNEL ENROLLED																				
b. NUMBER OF CASES COMPLETED																				
c. TOTAL INDEBTEDNESS *(Dollars)*																				
d. AVERAGE DEBT PER PERSON ENROLLMENT																				
4. CONSUMER COMPLIANTS																				
5. PUBLIC AWARENESS																				
a. BRIEFINGS/SPECIALIZED CLASSES																				
b. HANDBOOK																				
c. TV/RADIO ANNOUNCEMENT																				
d. CONSUMER GUIDLINES																				
6. MANDATORY FINANCIAL EDUCATION CLASSES																				

PART II - ADMINISTRATION					
SERVICES PROVIDED ADMINISTRATIVE SERVICES	TIME SPENT	SERVICES PROVIDED ADMINISTRATIVE SERVICES	TIME SPENT	SERVICES PROVIDED ADMINISTRATIVE SERVICES	TIME SPENT
1. REPORTS		3. CONSULTATION		6. PERSONNEL MANAGEMENT	
a. ACS - ANNUAL		a. CIVILIAN AGENCIES		a. STAFF MEETING	
b. FACMT CASE INCIDENT REPORT		b. MILITARY AGENCIES		b. VOLUNTEER MEETING	
c. MACOM REPORT		c. UNIT COMMANDER		c. STAFF EVALUATION	
d. INSPECTION REPORT		4. CASE MANAGEMENT		d. VOLUNTEER EVALUATION	
e. OTHER		a. CASE RECORDING		e. DEVELOPING JOB DESCRIPTION	
2. PROGRAM PLANNING		b. CASE PREPARATION		f. STAFF INTERVIEWS	
a. PREPARING SOP		5. BUDGETING		g. COUNSELING STAFF	
b. PROGRAM DEVELOPMENT		a. BUDGET PREPARATION		h. STAFF ASSIGNED OTHER RESPONSIBILITY OUTSIDE OF ACS ACTIVITIES	
c. GENERAL PROGRAM PLANNING		b. AUDITS			
d. DEVELOPING NEW INITIATIVES		c. UPDATING/POSTING ACCOUNTS		i. OTHERS	

PART III - TRAINING							
TRAINING PROVIDED IN COMPONENT AREA	TRAINEE POPULATION					TOTAL NUMBER TRAINED	TIME SPENT
	STAFF	VOUNTEERS	FIELD PLACEMENT STUDENTS	STAFF AND VOLUNTEERS OUTSIDE OF ACS			
				MILITARY AGENCIES	CIVILIAN AGENCIES		
1. RELOCATION SERVICE							
2. EMERGENCY ASSISTANCE							
3. INFORMATION AND REFERRAL							
4. EXCEPTIONAL FAMILY MEMBER							
a. RESPITE CARE							
b. TECHNIQUES IN WORKING WITH CHILDREN HAVING SPECIAL NEEDS							
5. FAMILY ADVOCACY							
a. TECHNIQUES IN PREVENTION							
b. TREATMENT METHODS							
c. OBSERVATION/ IDENTIFICATION							
d. FAMILY COUNSELING							
e. INDIVIDUAL COUNSELING							
f. GROUP COUNSELING							
g. PARENT/CHILD COUNSELING							
h. FAMILY ENRICHMENT CLASSES							

PART III - TRAINING *(Cont'd)*							
TRAINING PROVIDED IN COMPONENT AREA	TRAINEE POPULATION					TOTAL NUMBER TRAINED	TIME SPENT
	STAFF	VOLUNTEER	FIELD PLACEMENT STUDENTS	STAFF AND VOLUNTEERS OUTSIDE OF ACS			
				MILITARY AGENCIES	CIVILIAN AGENCIES		
6. ADMINISTRATION							
a. BUDGETING							
b. CONTRACTING							
c. PERSONNEL MANAGEMENT							
d. CASE RECORDING							
e. PROGRAM PLANNING TECHNIQUES							
f. PROGRAM EVALUATION							
g. RECORD-KEEPING							
h. NEED ASSESSMENT							
i. FACILITY PLANNING							
7. CONSUMER AFFAIR							
a. FINANCIAL PLANNING							
b. FINANCIAL COUNSELING							
c. CONSUMER EDUCATION							

ARMY COMMUNITY SERVICE PROGRAM REPORT

For use of this form, see AR 608-1; the proponent agency is TAGO.

REPORT CONTROL SYMBOL
AG-685 (R2)

PART I - INSTALLATION/MACOM IDENTIFYING DATA

A. ACS COMPLETE MAILING ADDRESS *(Include ZIP Code)*	B. MACOM CODE NAME OF MACOM	C. SUBORDINATE COMMAND CODE	D. ACS SERVICE AREA CODE

E. TELEPHONE NUMBER *(Include AUTOVON and Commercial Number)*	F. HOURS OF OPERATION	G. REPORTING PERIOD MONTH - YEAR / MONTH - YEAR

H. NAME, RANK/GRADE, TITLE OF ACS OFFICER/DIRECTOR	I. SIGNATURE OF ACS OFFICER/DIRECTOR

PART II - FISCAL DATA

A. ARMY COMMUNITY SERVICE FUNDING SOURCE

TOTAL DOLLARS

1. APPROPRIATED FUNDS _____ $ | | | | | | | | |
2. MORALE SUPPORT FUNDS _____ $ | | | | | | | | |
3. GIFT DONATIONS _____ $ | | | | | | | | |
4. GRANTS _____ $ | | | | | | | | |
5. OTHERS _____ $ | | | | | | | | |

B. ARMY EMERGENCY RELIEF FUNDING SOURCE

1. APPROPRIATED FUNDS _____ $ | | | | | | | | |
2. MORALE SUPPORT FUNDS _____ $ | | | | | | | | |

C. ARMY COMMUNITY SERVICE OPERATIONAL COST

1. MILITARY SALARIES AND BENEFITS _____ $ | | | | | | | | |
2. CIVILIAN PERSONNEL SALARIES AND BENEFITS _____ $ | | | | | | | | |
3. CONTRACTURAL COSTS _____ $ | | | | | | | | |
4. OTHER COSTS _____ $ | | | | | | | | |

PART II - FISCAL DATA *(Cont'd)*

D. ARMY EMERGENCY RELIEF OPERATIONAL COST — TOTAL DOLLARS

1. MILITARY SALARIES AND BENEFITS _____ $ | | | | | | | | |
2. CIVILIAN PERSONNEL SALARIES AND BENEFITS _____ $ | | | | | | | | |
3. CONTRACTURAL COSTS _____ $ | | | | | | | | |
4. OTHER COSTS _____ $ | | | | | | | | |

E. PROGRAM EXPENDITURES BY MAJOR ACS PROGRAM AREAS

1. CONSUMER AFFAIRS _____ $ | | | | | | | | |
2. EXCEPTIONAL FAMILY MEMBER _____ $ | | | | | | | | |
3. RELOCATION _____ $ | | | | | | | | |
4. INFORMATION, REFERRAL AND FOLLOW-UP _____ $ | | | | | | | | |
5. FOSTER CARE _____ $ | | | | | | | | |
6. FAMILY ADVOCACY _____ $ | | | | | | | | |
7. VOLUNTEER PROGRAM _____ $ | | | | | | | | |

PART III - PERSONNEL

A. ADMINISTRATIVE STAFF - *(Complete 1 thru 9 on each key Administrative Position)*

1. CHECK ONE BOX ON POSITION PERTINENT TO REPORTED POSITION.

a. ACS OFFICER/PROGRAM DIRECTOR _____ ☐
b. ACS COORDINATOR _____ ☐
c. NCOIC _____ ☐

2. GRADE OF INDIVIDUAL

a. E5 - E6 ☐
b. E7 - E9 ☐
c. 01 - 02 ☐
d. 03 - 04 ☐
e. 05 - 06 ☐
f. GS7 - 8 ☐
g. GS9 - 10 ☐
h. GS11 - 12 ☐
i. GS13 - ABOVE ☐

PART III - PERSONNEL *(Cont'd)*

3. POSITION AUTHORIZATIONS AND REQUIREMENTS

   a. REQUIRED, AUTHORIZED, STAFFED ☐
   b. REQUIRED, AUTHORIZED, NOT STAFFED ☐
   c. REQUIRED, NOT AUTHORIZED, STAFFED ☐
   d. REQUIRED, NOT AUTHORIZED, NOT STAFFED ☐
   e. NOT REQUIRED, STAFFED ☐

4. PERSONNEL STAFFED BELOW AUTHORIZED GRADE

   a. 1 LEVEL BELOW GRADE ☐
   b. 2 LEVELS BELOW GRADE ☐
   c. 3 LEVELS BELOW GRADE ☐
   d. 4 LEVELS OR MORE ☐

5. HOW MANY PEOPLE HAVE SERVED IN THIS POSITION IN THE LAST 3 YEARS

   a. 1 ☐
   b. 2 - 3 ☐
   c. 4 - 5 ☐
   d. 6 OR MORE ☐

6. IS THE POSITION STAFFED WITH CORRECT OCCUPATIONAL SERIES

   a. YES ☐
   b. NO ☐

PART III - PERSONNEL *(Cont'd)*

7. PERCENT OF TIME SPENT ON OTHER THAN ACS DUTIES

   a. LESS THAN 25% ☐
   b. 26 - 35% ☐
   c. 36 - 50% ☐
   d. 51 - 75% ☐
   e. 76% OR MORE ☐

8. IS POSITION FILLED BY SPECIAL DUTY *(SD)*/ADDITIONAL DUTY *(AD)*/EXCESS *(EX)* PERSONNEL

   a. SD ☐
   b. AD ☐
   c. EX ☐
   d. NONE OF THE ABOVE ☐

9. TRAINING RECEIVED BY PERSONNEL

   a. ACS COURSE *(Only)* ☐
   b. ARMY AND OTHER DOD SPONSORED PROFESSIONAL TRAINING IN ACS OR RELATED AREA ☐
   c. NON-DOD PROFESSIONAL TRAINING ☐
   d. ACS COURSE, ARMY SPONSORED TRAINING AND/OR NON-DOD PROFESSIONAL TRAINING ☐
   e. NO TRAINING ☐

B. PROGRAM COORDINATORS WITH SOLE RESPONSIBILITY FOR ONE PROGRAM AREA
(Complete 1 thru 8 on each program coordinator)

1. CHECK ONE BOX ON A POSITION PERTINENT TO REPORTED POSITION

   a. INFORMATION AND REFERRAL COORDINATOR ☐
   b. RELOCATION COORDINATOR ☐
   c. CONSUMER AFFAIRS COORDINATOR ☐

PART III - PERSONNEL *(Cont'd)*

B. PROGRAM COORDINATORS WITH SOLE RESPONSIBILITY FOR ONE PROGRAM AREA *(Cont'd)*

d. FAMILY ADVOCACY COORDINATOR ☐

e. EXCEPTIONAL FAMILY MEMBER COORDINATOR ☐

f. FOSTER CARE COORDINATOR ☐

2. GRADE OF INDIVIDUAL

a. E5 - E6 ☐

b. E7 - E9 ☐

c. 01 - 02 ☐

d. 03 - 04 ☐

e. 05 -06 ☐

f. GS7 - 8 ☐

g. GS9 - 10 ☐

h. GS11 -12 ☐

i. GS13 - ABOVE ☐

3. POSITION AUTHORIZATIONS AND REQUIREMENTS

a. REQUIRED, AUTHORIZED, STAFFED ☐

b. REQUIRED, AUTHORIZED, NOT STAFFED ☐

c. REQUIRED, NOT AUTHORIZED, STAFFED ☐

d. REQUIRED, NOT AUTHORIZED, NOT STAFFED ☐

e. NOT REQUIRED, STAFFED ☐

4. PERSONNEL STAFFED BELOW AUTHORIZED GRADE

a. 1 LEVEL BELOW GRADE ☐

b. 2 LEVELS BELOW GRADE ☐

c. 3 LEVELS BELOW GRADE ☐

d. 4 LEVELS OR MORE ☐

PART III - PERSONNEL *(Cont'd)*

5. HOW MANY PEOPLE HAVE SERVED IN THIS POSITION IN THE LAST 3 YEARS

   a. 1 ☐

   b. 2 - 3 ☐

   c. 4 - 5 ☐

   d. 6 OR MORE ☐

6. IS THE POSITION STAFFED WITH CORRECT OCCUPATIONAL SERIES

   a. YES ☐

   b. NO ☐

7. IS POSITION FILLED BY SPECIAL DUTY *(SD)*/ADDITIONAL DUTY *(AD)*/EXCESS *(EX)* PERSONNEL

   a. SD ☐

   b. AD ☐

   c. EX ☐

   d. NONE OF THE ABOVE ☐

8. TRAINING RECEIVED BY PERSONNEL

   a. ACS COURSE *(Only)* ☐

   b. ARMY AND OTHER DOD SPONSORED PROFESSIONAL TRAINING IN ACS OR RELATED AREA ☐

   c. NON-DOD PROFESSIONAL TRAINING ☐

   d. ACS COURSE, ARMY SPONSORED TRAINING AND/OR NON-DOD PROFESSIONAL TRAINING ☐

   e. NO TRAINING ☐

PART III - PERSONNEL *(Cont'd)*

C. PROGRAM COORDINATORS WITH MULTIPLE ACS PROGRAM RESPONSIBILITIES
(Complete 1 thru 9 on each person with multiple responsibilities)

1. CHECK ONE BOX ON POSITION PERTINENT TO REPORTED POSITION

a. INFORMATION AND REFERRAL COORDINATOR ☐
b. RELOCATION COORDINATOR ☐
c. CONSUMER AFFAIRS COORDINATOR ☐
d. FAMILY ADVOCACY COORDINATOR ☐
e. EXCEPTIONAL FAMILY MEMBER COORDINATOR ☐
f. FOSTER CARE COORDINATOR ☐
g. SOCIAL WORKER ☐

2. GRADE OF INDIVIDUAL

a. E5 - E6 ☐
b. E7 - E9 ☐
c. 01 - 02 ☐
d. 03 - 04 ☐
e. 05 - 06 ☐
f. GS7 - 8 ☐
g. GS9 - 10 ☐
h. GS11 - 12 ☐
i. GS13 - ABOVE ☐

3. POSITION AUTHORIZATIONS AND REQUIREMENTS

a. REQUIRED, AUTHORIZED, STAFFED ☐
b. REQUIRED, AUTHORIZED, NOT STAFFED ☐
c. REQUIRED, NOT AUTHORIZED, STAFFED ☐
d. REQUIRED, NOT AUTHORIZED, NOT STAFFED ☐
e. NOT REQUIRED, STAFFED ☐

PART III - PERSONNEL *(Cont'd)*

4. PERSONNEL STAFFED BELOW AUTHORIZED GRADE

   a. 1 LEVEL BELOW GRADE ☐

   b. 2 LEVELS BELOW GRADE ☐

   c. 3 LEVELS BELOW GRADE ☐

   d. 4 LEVELS OR MORE ☐

5. HOW MANY PEOPLE HAVE SERVED IN THIS POSITION IN THE LAST 3 YEARS

   a. 1 ☐

   b. 2 - 3 ☐

   c. 4 - 5 ☐

   d. 6 OR MORE ☐

6. IS THE POSITION STAFFED WITH CORRECT OCCUPATIONAL SERIES

   a. YES ☐

   b. NO ☐

7. NUMBER OF ACS PROGRAMS RESPONSIBLE FOR

   a. 2 ☐

   b. 3 ☐

   c. 4 ☐

   d. 5 ☐

PART III - PERSONNEL *(Cont'd)*

8. IS POSITION FILLED BY SPECIAL DUTY *(SD)*/ADDITIONAL DUTY *(AD)*/EXCESS *(EX)* PERSONNEL

   a. SD _____ ☐

   b. AD _____ ☐

   c. EX _____ ☐

   d. NONE OF THE ABOVE _____ ☐

9. TRAINING RECEIVED BY PERSONNEL

   a. ACS COURSE *(Only)* _____ ☐

   b. ARMY AND OTHER DOD SPONSORED PROFESSIONAL TRAINING IN ACS OR RELATED AREA _____ ☐

   c. NON-DOD PROFESSIONAL TRAINING _____ ☐

   d. ACS COURSE, ARMY SPONSORED TRAINING AND/OR NON-DOD PROFESSIONAL TRAINING _____ ☐

   e. NO TRAINING _____ ☐

D. TOTAL NUMBER OF PAID STAFF

	TOTAL NUMBERS
1. MILIARY	
2. CIVILIAN	
3. CONTRACTED	
a. FULL-TIME	
b. PART-TIME	

PART III - PERSONNEL *(Cont'd)*

E. TOTAL NUMBER OF VOLUNTEER

TOTAL NUMBERS

1. FAMILY MEMBER OF ACTIVE DUTY _____
2. ACTIVE DUTY _____
3. CIVILIAN _____
4. MILITARY RETIREE _____
5. FAMILY MEMBER OF MILITARY RETIREE _____

F. TOTAL NUMBER OF VOLUNTEER HOURS _____

PART IV - SERVICES PROVIDED

A. INFORMATION, REFERRAL, AND FOLLOW-UP

TOTAL NUMBERS SERVED

1. E1 - E4 _____
2. E5 - E6 _____
3. E7 - E9 _____
4. W1 - W4 _____
5. 01 - 03 _____
6. 04 - 06 _____
7. CIVILIAN _____
8. RETIREE _____

B. RELOCATION SERVICES

1. E1 - E4 _____
2. E5 - E6 _____
3. E7 - E9 _____
4. W1 - W4 _____
5. 01 - 03 _____

PART IV - SERVICES PROVIDED *(Cont'd)*

B. RELOCATION SERVICES *(Cont'd)*

TOTAL NUMBERS SERVED

6. 04 - 06 _____
7. CIVILIAN _____
8. RETIREE _____

C. EXCEPTIONAL FAMILY MEMBER PROGRAM

1. E1 - E4 _____
2. E5 - E6 _____
3. E7 - E9 _____
4. W1 - W4 _____
5. 01 - 03 _____
6. 04 - 06 _____
7. CIVILIAN _____
8. RETIREE _____

D. SPOUSE ABUSE

1. E1 - E4 _____
2. E5 - E6 _____
3. E7 - E9 _____
4. W1 - W4 _____
5. 01 - 03 _____
6. 04 - 06 _____
7. CIVILIAN _____
8. RETIREE _____

PART IV - SERVICES PROVIDED *(Cont'd)*

E. CHILD ABUSE AND NEGLECT

TOTAL NUMBERS SERVED

1. E1 - E4
2. E5 - E6
3. E7 - E9
4. W1 - W4
5. 01 - 03
6. 04 - 06
7. CIVILIAN
8. RETIREE

F. FOSTER CARE PROGRAM

1. E1 - E4
2. E5 - E6
3. E7 - E9
4. W1 - W4
5. 01 - 03
6. 04 - 06
7. CIVILIAN
8. RETIREE

G. CONSUMER AFFAIRS

1. E1 - E4
2. E5 - E6
3. E7 - E9

PART IV - SERVICES PROVIDED *(Cont'd)*

G. CONSUMER AFFAIRS *(Cont'd)*

TOTAL NUMBERS SERVED

4. W1 - W4 _____ | | | | | | |
5. 01 - 03 _____ | | | | | | |
6. 04 - 06 _____ | | | | | | |
7. CIVILIAN _____ | | | | | | |
8. RETIREE _____ | | | | | | |

H. DEBT COUNSELING

1. E1 - E4 _____ | | | | | | |
2. E5 - E6 _____ | | | | | | |
3. E7 - E9 _____ | | | | | | |
4. W1 - W4 _____ | | | | | | |
5. 01 - 03 _____ | | | | | | |
6. 04 - 06 _____ | | | | | | |
7. CIVILIAN _____ | | | | | | |
8. RETIREE _____ | | | | | | |

I. LEVEL OF SOLDIER INDEBTNESS

TOTAL DOLLARS

1. TOTAL INDEBTNESS IN DOLLARS _____ $ | | | | | | | | |
2. TOTAL DEBT REDUCED IN DOLLARS _____ $ | | | | | | | | |

PART IV - SERVICES PROVIDED (Cont'd)

J. EMERGENCY ASSISTANCE — TOTAL NUMBERS SERVED

1. E1 - E4
2. E5 - E6
3. E7 - E9
4. W1 - W4
5. 01 - 03
6. 04 - 06
7. CIVILIAN
8. RETIREE

K. SPOUSE EMPLOYMENT ASSISTANCE

1. E1 - E4
2. E5 - E6
3. E7 - E9
4. W1 - W4
5. 01 - 03
6. 04 - 06
7. CIVILIAN
8. RETIREE

PART V - PUBLIC AWARENESS AND PREVENTATIVE EDUCATION

TOTAL NUMBERS

A. TOTAL NUMBER OF CLASSES, BRIEFINGS, AND WORKSHOPS CONDUCTED

B. TOTAL NUMBER OF PERSONS IN ATTENDANCE

REMARKS *(Use separate sheet if necessary)*

*U.S. GOVERNMENT PRINTING OFFICE: 1983-0-405-762/1104

c. RELATIONSHIP CODES

FATHER	01	STEPBROTHER	11	TEACHER	21
STEPFATHER	02	SISTER	12	CHILD CARE PERSONNEL	22
ADOPTIVE FATHER	03	HALFSISTER	13	BABYSITTER	23
FOSTER FATHER	04	STEPSISTER	14	FRIEND OF FAMILY	24
MOTHER	05	NEPHEW	15	GRANDFATHER (P)	25
STEPMOTHER	06	NIECE	16	GRANDMOTHER (P)	26
ADOPTIVE MOTHER	07	UNCLE (P)	17	GRANDFATHER (M)	27
FOSTER MOTHER	08	AUNT (P)	18	GRANDMOTHER (M)	28
BROTHER	09	UNCLE (M)	19	HUSBAND	29
HALFBROTHER	10	AUNT (M)	20	WIFE	30
				FRIEND OF THE ABUSED	31
				OTHER_____ *(Specify)*	32

XII. DESCRIPTIVE STATEMENT

DATE	NAME, RANK, TITLE OF PREPARER OF REPORT	SIGNATURE

APPLICATION FOR RESPITE CAREGIVERS

For use of this form, see AR 608-1; the proponent agency is TAGO.

DATA REQUIRED BY THE PRIVACY ACT

AUTHORITY: Title 6, United States Code, Section 301
PRINCIPAL PURPOSE: To recruit and select respite care givers.
ROUTINE USES: To determine the prospective respite care givers ability to care for handicapped individuals.
DISCLOSURE: Providing information is voluntary. Failure to provide information will result in disapproval of prospective respite caregiver's application.

NAME	BIRTHDATE

MAIDEN NAME *(Applicant or spouse)*	SPOUSE'S NAME

ADDRESS *(Street, city and state) (Include ZIP Code)*	TELEPHONE NO. HOME: OFFICE:	SOCIAL SECURITY NO.

BRIEFLY DESCRIBE BACKGROUND, INTEREST, AND/OR EXPERIENCE WORKING WITH HANDICAPPED CHILDREN OR ADULTS.

AVAILABILITY FOR PROVIDING CARE

EVENINGS ☐ YES ☐ NO WEEKENDS ☐ YES ☐ NO

DAYS ☐ YES ☐ NO

OVERNIGHT WEEKDAYS ☐ YES ☐ NO OVERNIGHT WEEKENDS ☐ YES ☐ NO

WILL PROVIDE CARE

☐ IN HOME OF CLIENT ☐ IN MY OWN HOME ☐ NO PREFERENCE

DO YOU HAVE OWN TRANSPORTATION ☐ YES ☐ NO	AGE GROUP PREFERENCE

EDUCATION *(High school, college, graduate studies, other)*

NAME AND ADDRESS OF SCHOOL	DATES ATTENDED	MAJOR	DEGREE

EMPLOYMENT *(Present, and last three years)*

NAME AND ADDRESS OF EMPLOYER	DATES EMPLOYED	POSITION

REFERENCES *(List three, other than relative. Example: Pastor, supervisor, co-worker)*

NAME AND ADDRESS *(Give complete mailing address) (Include ZIP Code)*	OCCUPATION

I hereby certify that all statements in this application are true to the best of my knowledge and belief.

SIGNATURE	DATE

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MEDICAL REPORT ON APPLICANT FOR CERTIFICATION TO PROVIDE CARE FOR HANDICAPPED CHILDREN OR ADULTS

For use of this form, see AR 608-1; the proponent agency is TAGO.

NAME	DATE

FOR EXAMINING PHYSICIAN

Application is being made to obtain certification to care for handicapped children or adults in their homes. We need to know if applicant has any health problems and the extent and significance of such problems insofar as they may affect applicant's ability to provide care to unrelated children or adults. This information is for confidential use.

CHECK APPROPRIATE BOXES AND EXPLAIN "NO" ANSWERS IN SPACE BELOW

1. IS THE APPLICANT FREE FROM ACUTE OR CHRONIC DISEASE THAT MIGHT AFFECT THE HEALTH OR DEVELOPMENT OF CHILDREN OR ADULTS UNDER CARE? ☐ YES ☐ NO

2. IN YOUR OPINION, IS THE APPLICANT FREE FROM ANY NERVOUS OR EMOTIONAL DISORDER THAT WOULD AFFECT THE WELL BEING OF THE INDIVIDUALS CARED FOR? ☐ YES ☐ NO

3. DO YOU BELIEVE THE APPLICANT IS PHYSICALLY AND EMOTIONALLY CAPABLE OF CARING FOR MENTALLY RETARDED AND/OR PHYSICALLY HANDICAPPED CHILDREN AND ADULTS? ☐ YES ☐ NO

A CHEST X-RAY OR TUBERCULIN TEST IS REQUIRED. IF EITHER TEST HAS BEEN DONE THROUGH YOUR OFFICE WITHIN THE LAST THREE MONTHS WOULD YOU INDICATE THE DATE GIVEN AND RESULT *(POSITIVE, OR NEGATIVE)*

CHEST X-RAY		TUBERCULIN TEST	
DATE:	RESULT:	DATE:	RESULT:

TYPED NAME AND ADDRESS OF PHYSICIAN	SIGNATURE

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

I agree to the release of medical information to the ACS Respite Care Program.

SIGNATURE *(Applicant)*	DATE

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APPLICATION FOR RESPITE CARE FOR HANDICAPPED CHILDREN AND ADULTS

For use of this form, see AR 608-1; the proponent agency is TAGO.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY:	Title 5, United States Code, Section 301.
PRINCIPAL PURPOSE:	To identify specific handicap of individual requiring respite care.
ROUTINE USES:	To identify specific problems that handicapped individual is experiencing and to determine type of care needed.
DISCLOSURE:	Providing information is voluntary. Failure to provide information will result in disapproval of prospective respite care user's application.

IDENTIFYING AND RESOURCE INFORMATION

NAME *(Handicapped person) (Last, first, MI)*		NAME *(Parent, guardian, or responsible family member)*
BIRTHDATE	ADDRESS *(Include ZIP Code)*	TELEPHONE NUMBERS HOME FATHER *(work)* MOTHER *(work)*

EMERGENCY CONTACT *(Relative, friend, etc.) (Name, address and telephone number)*

IF THIS EMERGENCY CONTACT IS NOT AVAILABLE TO SUBSTITUTE FOR THE CAREGIVER IN AN EMERGENCY, PLEASE GIVE THE NAME, ADDRESS AND TELEPHONE NUMBER OF A PERSON WHO HAS AGREED TO BE AVAILABLE AND TO ACCEPT RESPONSIBILITY FOR THE HANDICAPPED PERSON IN THE EVENT YOU CANNOT BE REACHED.

LIST OTHER HOUSEHOLD MEMBERS

NAME	BIRTHDATE

PHYSICIAN *(Name, address and telephone no.)*	DENTIST *(Name, address and telephone no.)*
PREFERRED HOSPITAL *(Name and address)*	REGULAR PROGRAM ATTENDED BY INDIVIDUAL *(School, sheltered work, etc.)*

DESCRIPTIVE INFORMATION *(Handicapped Individual)*

DESCRIBE INDIVIDUAL'S HANDICAPPING CONDITION(S)

DESCRIBE ANY CHRONIC MEDICAL PROBLEMS A CAREGIVER SHOULD BE AWARE OF

LIST ANY ALLERGIES		
IS THERE A HISTORY OF SEIZURES *(If yes, what kind and how often)*		
DESCRIBE ANY SPECIAL EQUIPMENT THE INDIVIDUAL USES *(Braces, wheelchair, etc.)*	INDIVIDUAL'S HEIGHT	WEIGHT

INDICATE THE EXTENT TO WHICH THE INDIVIDUAL CAN DO ANY OF THE FOLLOWING	
USE TOILET	STAND
TRANSFER INDEPENDENTLY	WALK
TALK	FEED SELF
CLIMB STAIRS	BATHE SELF
DRINK FROM A GLASS	SIT UP ALONE
DRESS SELF	UNDERSTAND WORDS

INSTRUCTIONS FOR CARE AND/OR SUPERVISION

LIST ANY MEDICATION GIVEN REGULARLY AND THE PURPOSE FOR WHICH IT IS USED

DESCRIBE SPECIAL INSTRUCTIONS FOR HANDLING SPECIFIC MEDICAL CONDITIONS *(Seizures, allergies, etc.)*

DESCRIBE SPECIAL INSTRUCTIONS FOR HANDLING BODILY FUNCTIONS *(Toileting, transfering, mobility, feeding, etc.)*

DESCRIBE WHEN AND HOW SPECIAL EQUIPMENT IS USED

DESCRIBE SPECIAL DIET REQUIREMENTS AND MEALTIME INSTRUCTIONS

DESCRIBE SLEEPING HABITS AND BEDTIME INSTRUCTIONS

DESCRIBE SPECIAL BEHAVIORAL PROBLEMS AND METHOD OF HANDLING

DESCRIBE THE EXTENT OF SUPERVISION THE INDIVIDUAL NEEDS

DESCRIBE FAVORITE RECREATIONAL ACTIVITIES

LIST ANY OTHER INSTRUCTIONS OR COMMENTS NOT DESCRIBED ABOVE

PREFERENCE FOR LOCATION OF RESPITE CARE

INDICATE WHICH OF THE FOLLOWING LOCATIONS YOU PREFER FOR RESPITE CARE IF A CHOICE IS AVAILABLE

☐ YOUR HOME ☐ HOME OF THE CAREGIVER ☐ NO PREFERENCE

CLINICIAN'S INFORMATION

For use of this form, see AR 608-1; the proponent agency is TAGO.

PERMISSION FOR RELEASE OF MEDICAL INFORMATION

I agree to the release of medical information to the ACS Respite Care Program.

(Date) *(Signature of Patient or responsible parent)*

FOR CLINICIAN

Application is being made to the ACS Respite Care Program to receive respite care services. Respite care is temporary relief care given by caregivers, trained and certified by ACS to help handicapped children and adults, many of whom are developmentally disabled in order to provide a respite period for family members responsible for their regular care. Respite care can vary in length from a few hours to a week or more. The program provides two levels of respite care: supervision only and personal care.

We need to know, therefore, the level of care the applicant requires and any relevant information about medical conditions and special care instructions. Would you please provide the answers to the questions on this form and give explanations when indicated. This information is for confidential use.

NAME *(PATIENT)*	BIRTHDATE

ADDRESS

IF APPLICANT REQUIRES ANY PERSONAL CARE, EXPLAIN HOW CARE IS NEEDED.

BATHING

SKIN AND HAIR CARE

SHAVING

FEEDING

TRANSFERRING

LIFTING

ASSISTIVE DEVICES

TOILETING

ADMINISTRATION OF MEDICATION

EXERCISING

MONITORING OF BODY FUNCTIONS

OTHER

IF APPLICANT REQUIRES SUPERVISION WHEN PERFORMING CERTAIN FUNCTION FOR HIMSELF/HERSELF, EXPLAIN SUPERVISION NEEDED.

BATHING AND BODY CARE

TOILETING

MOBILITY

USE OF MEDICATIONS

USE OF ASSISTIVE DEVICES

MENTAL FUNCTIONS *(Including capacity for sound judgment)*

NUTRITIONAL NEEDS

OTHER

IF THERE IS ANY RELEVANT INFORMATION NOT DESCRIBED ABOVE THAT THE CAREGIVER SHOULD BE AWARE OF, PLEASE EXPLAIN.

MEDICAL CONDITIONS

MEDICATIONS

SPECIAL DIETS

SPECIAL CARE

OTHER

PHYSICIAN *(Name, address and telephone number)* *(Type or print)*

DATE	SIGNATURE

INFORMATION ON HANDICAPPED INDIVIDUAL

For use of this form, see AR 608-1; the proponent agency is TAGO.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 5. USC, Section 301.
PRINCIPAL PURPOSE: To identify specific needs of handicapped individual requiring respite care.
ROUTINE USES: To provide information regarding handicapped individual to caregiver.
DISCLOSURE: Providing information is voluntary. Failure to provide information will result in disapproval of prospective respite care user's application.

NAME *(Handicapped Person) (Last, First, MI)*	NAME *(Parent, or person completing this form)*
ADDRESS *(Include ZIP Code)*	TELEPHONE NUMBERS HOME FATHER *(work)* MOTHER *(work)*

NAMES AND AGES OF CHILDREN IN HOME

NAME	AGE

AGE OF HANDICAPPED

WEIGHT

PERSONS TO CONTACT IN CASE OF AN EMERGENCY

NAME, ADDRESS AND TELEPHONE NUMBER	NAME, ADDRESS AND TELEPHONE NUMBER

GIVE BRIEF DESCRIPTION OF INDIVIDUAL'S HANDICAPPING CONDITION(S)

IS SPECIAL EQUIPMENT USED *(Braces, wheelchairs, etc)*	IF SPECIAL EQUIPMENT IS USED, WHEN AND HOW USED
☐ YES ☐ NO	

DOES INDIVIDUAL *(Check appropriate boxes)*

STAND ☐ YES ☐ NO BATHE SELF ☐ YES ☐ NO WALK ☐ YES ☐ NO

SIT UP ALONE ☐ YES ☐ NO DRINK FROM A GLASS ☐ YES ☐ NO

FEED SELF ☐ YES ☐ NO TALK ☐ YES ☐ NO UNDERSTAND WORDS ☐ YES ☐ NO

MEALTIME *(Please describe your typical menu for a full day)*

BREAKFAST	LUNCH	DINNER

SPECIAL MEALTIME OR DIET INSTRUCTIONS

SNACKS *(List, if any)*

BEDTIME

WHEN DOES HE/SHE GO TO BED	WHEN DOES HE/SHE TAKE NAPS

SLEEPING OR BEDTIME HABITS CAREGIVER SHOULD KNOW ABOUT

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DAILY ACTIVITIES

DESCRIBE A TYPICAL DAY'S SCHEDULE

PROGRAM *(If in a regular program, list name, i.e. school, work, etc. and address)*

TELEPHONE NO.	TRANSPORTATION PICK-UP TIME	RETURN TIME	DAYS AND TIME *(List days of the week and times of program)*

FAVORITE RECREATIONAL OR PLAY ACTIVITIES

MEDICAL INFORMATION

LIST ALL MEDICATION GIVEN REGULARLY	LIST ANY ALLERGIES

IS THERE A HISTORY OF SEIZURES *(If yes, what kind and how often do they occur)*

☐ YES ☐ NO

WHAT DO YOU DO WHEN SEIZURES OCCUR

LIST ANY CHRONIC MEDICAL PROBLEMS OR INSTRUCTIONS THE CAREGIVER SHOULD BE AWARE OF

PHYSICIAN *(Name and telephone no.)*	DENTIST *(Name and telephone no.)*

PREFERRED HOSPITAL *(Name and Address)*	HOSPITAL INSURANCE *(Name of company)*

SPECIAL INSTRUCTIONS FOR OTHER FAMILY MEMBERS IN CAREGIVER'S CHARGE

IMPORTANT: (BE SURE TO PROVIDE THIS INFORMATION FOR THE CAREGIVER EACH TIME YOU GO OUT)

I/WE CAN BE REACHED AT THE FOLLOWING

LOCATION	DATE AND TIME	TELEPHONE NO.

It is very important that the caregiver have your permission to seek medical help if needed. Please update or rewrite the permission form each time a new caregiver is in charge.

_____

(Caregiver's name)

is in full charge of _____

during my absence. I give the caregiver permission to request or approve any medical attention needed by the above named individual(s), and to administer medications according to my written instructions. He/she will not be held responsible or liable in any way for any accident or illness that may occur.

_____ _____

(Date) *(Signature of Parent or Guardian)*

FAMILY IDENTIFICATION SHEET FOR A CHILD RECEIVING SERVICE

For use of this form, see AR 608-1; the proponent agency is TAGO.

CHILD'S CASE NUMBER

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 5, United States Code, Section 301.
PRINCIPAL PURPOSE: To provide essential background information to develop a service plan for each child and family involved in the foster care delivery process.
ROUTINE USES: (1) To identify problems the child/family is experiencing; (2) to select a foster home which can best meet the needs of the child; (3) to make long range plans for the child.
DISCLOSURE: Providing information is voluntary. No adverse effect on the individual.

NAME *(Child)* | SOCIAL SECURITY NO.

INFORMATION ON PARENTS

NATURAL FATHER	NATURAL MOTHER
NAME *(Full name, nickname, alias)*	NAME *(Include maiden name)*
ADDRESS *(Include ZIP Code)*	ADDRESS *(Include ZIP Code)*
DATE OF BIRTH *(Month, day year)*	DATE OF BIRTH *(Month, day, year)*
PLACE OF BIRTH *(State, County, town or city)*	PLACE OF BIRTH *(State, County, town or city)*
RACE AND CITIZENSHIP	RACE AND CITIZENSHIP

PHYSICAL DESCRIPTION

HEIGHT	WEIGHT	COLOR HAIR	COLOR EYES	SKIN

PHYSICAL DESCRIPTION

HEIGHT	WEIGHT	COLOR HAIR	COLOR EYES	SKIN

NATURAL FATHER	NATURAL MOTHER
BIRTHMARKS, SCARS	BIRTHMARKS, SCARS
HANDICAPS	HANDICAPS
CHRONIC ILLNESS / WEARS GLASSES ☐ YES ☐ NO	CHRONIC ILLNESS / WEARS GLASSES ☐ YES ☐ NO
EDUCATION ☐ GRADE SCHOOL ☐ HIGH SCHOOL ☐ COLLEGE	EDUCATION ☐ GRADE SCHOOL ☐ HIGH SCHOOL ☐ COLLEGE
VOCATIONAL AND OTHER TRAINING	VOCATIONAL AND OTHER TRAINING
SOCIAL SECURITY NUMBER / EMPLOYED ☐ YES ☐ NO	SOCIAL SECURITY NUMBER / EMPLOYED ☐ YES ☐ NO
OCCUPATION(S)	OCCUPATION(S)
UNION MEMBER ☐ YES ☐ NO / LOCAL UNION NUMBER AND NAME	UNION MEMBER ☐ YES ☐ NO / LOCAL UNION NUMBER AND NAME

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INFORMATION ON PARENTS *(cont'd)*

NATURAL FATHER		NATURAL MOTHER	
MILITARY SERVICE AND DATES		MILITARY SERVICE AND DATES	
TYPE OF DISCHARGE	SERIAL NUMBER	TYPE OF DISCHARGE	SERIAL NUMBER
CLAIM NUMBER		CLAIM NUMBER	
DENOMINATION		DENOMINATION	
CHURCH NAME AND ADDRESS *(Include ZIP Code)*		CHURCH NAME AND ADDRESS *(Include ZIP Code)*	

MARITAL STATUS OF NATURAL PARENTS

☐ NEVER MARRIED ☐ MARRIED TO EACH OTHER _____ *(Date)* _____ *(Place)*

_____ *(How verified)*

☐ NEVER ☐ MAINTAINED A HOME TOGETHER _____ *(State)* _____ *(County)* _____ *(City)*

NOW, ☐ LIVING TOGETHER ☐ SEPARATED ☐ DIVORCED _____ *(Date)* _____ *(Place)*

_____ *(How verified)*

☐ PATERNITY ESTABLISHED BY COURT ORDER _____ *(Date)* _____ *(Court)*

NAME OF LEGAL FATHER IF NOT NATURAL FATHER *(Above)* _____

FATHER *(If deceased)*	MOTHER *(If deceased)*
DATE AND PLACE OF DEATH	DATE AND PLACE OF DEATH
CAUSE OF DEATH	CAUSE OF DEATH

OTHER CHILDREN FROM UNION OF NATURAL PARENTS

NAME	BIRTHDATE	OTHER INFORMATION

NATURAL FATHER'S RELATIVES *(Parents, siblings, children, other unions)*		
NAME	RELATIONSHIP	ADDRESS

NATURAL MOTHER'S RELATIVES *(Parents, siblings, children, other unions)*		
NAME	RELATIONSHIP	ADDRESS

CHANGES IN WHEREABOUTS *(Relatives listed above)*			
NATURAL FATHER		NATURAL MOTHER	
DATE	NAME AND ADDRESS	DATE	NAME AND ADDRESS

CHILD'S FACE AND WHEREABOUTS SHEET

For use of this form, see AR 608-1; the proposed agency is TAGD.

CASE NUMBER

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 5, United States Code, Section 301.
PRINCIPAL PURPOSE: To provide essential background information to develop a service plan for each child and family involved in the foster care delivery process.
ROUTINE USES: (1) To identify problems the child/family is experiencing; (2) To select a foster home which can best meet the needs of the child; (3) To make long range plans for the child.
DISCLOSURE: Providing information is voluntary. No adverse effect on the individual.

NAME OF CHILD *(Last, first, middle)*			ALIAS AND/OR NICKNAME
RACE	SEX	RELIGION	BAPTIZED ☐ YES ☐ NO
BIRTHDATE *(month, day, year)*	BIRTHDATE VERIFIED ☐ YES ☐ NO	DATE VERIFIED	PHOTO COPY FILED ☐ YES ☐ NO

BIRTHPLACE *(Name of hospital, or street, or R.F.D. number, city or town, county and state)*

NAME OF MOTHER *(Last, first, middle, maiden)*

ALIAS AND/OR NICKNAME

RACE	RELIGION

NAME OF LEGAL FATHER *(Last, first, middle)*

ALIAS AND/OR NICKNAME

RACE	RELIGION

FAMILY CASE NUMBER	FAMILY CASE NAME

FAMILY OR AGENCY WITH WHOM CHILD LIVED WHEN ACCEPTED

NAME AND ADDRESS	RELATIONSHIP

APPLICATION *(Date)*	ACCEPTANCE *(Date)*	FIRST PLACEMENT *(Date)*

COURT

COURT *(Name)*

DOCKET NUMBER	ORDER OF DETENTION *(Date)*	COMMITMENT *(Date(s))*

FINDINGS

GUARDIANSHIP FOR ADOPTION

DATE *(Guardianship for adoption)*	COURT *(Name)*

DATES GUARDIANSHIP RENEWED ON

DATE	DATE	DATE	DATE	DATE
DATE	DATE	DATE	DATE	DATE

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NOTE: WHEN NAME IS THAT OF FOSTER FAMILY USE PAYEE NAME			
DATE	NAME OF FAMILY, AGENCY INSTITUTION AND CASE NUMBER	ADDRESS *(Street, box no. county, city and state)*	LIVING ARRANGEMENT
	CASE NO.		
	CASE NO.		
	CASE NO.		
	CASE NO.		
	CASE NO.		
	CASE NO.		
	CASE NO.		
	CASE NO.		
	CASE NO.		

CHILD INFORMATION

For use of this form see AR 608-1; the proponent agency is TAGO.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 5, United States Code, Section 301.
PRINCIPAL PURPOSE: To provide essential background information to develop a service plan for each child and family involved in the foster care delivery process.
ROUTINE USES: (1) To identify problems the child/family is experiencing; (2) To select a foster home which can best meet the needs of the child; (3) To make long range plans for the child.
DISCLOSURE: *Providing information is voluntary. No adverse effect on the individual.*

NAME OF CHILD	BIRTHDATE

NICKNAME	VERIFIED ☐ YES ☐ NO

BIRTHPLACE *(Hospital or home address)*

BIRTH DELIVERY *(Check one)*

☐ NORMAL ☐ BEFORE EXPECTED ☐ LATER THAN EXPECTED

BIRTH WEIGHT	BIRTH MARKS

FEEDING *(Check one)* ☐ EARLY FEEDING ☐ BREAST FED ☐ BOTTLE	WEANING AGE

WALKED FIRST WHEN HE/SHE WAS *(Age)*	TALKED FIRST WHEN HE/SHE WAS *(Age)*	WHEN TOILET TRAINED *(Age)*

HOW TOILET TRAINED

WHAT KIND OF EATER *(Check one)* ☐ HEARTY ☐ PICKY ☐ IN BETWEEN	HAS CHILD EVER EATEN PAINT OR PLASTER *(If yes, give details)*

ALLERGIES *(Medications, dust, food, etc.)*

DOES CHILD GO TO TOILET ALONE ☐ YES ☐ NO	WHAT LAXATIVES HAS CHILD BEEN USED TO TAKING?

WHAT TIME DOES CHILD GO TO BED	IS LIGHT LEFT ON ☐ YES ☐ NO	SLEEPING CLOTHES	SLEEPS ALONE ☐ YES ☐ NO

WHAT DOES CHILD TAKE TO BED WITH HIM/HER	NIGHTMARES ☐ YES ☐ NO	WHAT TIME DOES CHILD GET UP	RISING TIME

HOW OFTEN DOES CHILD TAKE BATHS	DOES CHILD TAKE CARE OF CLOTHES, INCLUDING SHOES ☐ YES ☐ NO

DOES CHILD WEAR GLASSES ☐ YES ☐ NO	IF CHILD WEARS GLASSES, HOW DOES HE/SHE HANDLE THEM

WHAT DOES CHILD KNOW ABOUT SEX

HEALTH DATA

For use of this form see AR 608-1; the proponent agency is TAGO.

CASE NUMBER

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 5, United States Code, Section 301.

PRINCIPAL PURPOSE: To provide essential background information to develop a service plan for each child and family involved in the foster care delivery process.

ROUTINE USES: (1) To identify problems the child/family is experiencing; (2) To select a foster home which can best meet the needs of the child; (3) To make long range plans for the child.

DISCLOSURE: Providing information is voluntary. No adverse effect on the individual.

NAME OF CHILD	BIRTHDATE	DATE

CHRONIC ILLNESS AND HANDICAPS

IMMUNIZATIONS			COMMUNICABLE AND CHILDHOOD DISEASES	
TYPE	DATE	WHERE GIVEN	TYPE	DATE
SMALL POX			MEASLES	
BOOSTER			MUMPS	
DPT 1ST			CHICKEN POX	
DPT 2ND			OTHER	
DPT 3RD				
SALK 1ST				
SALK 2ND				
SALK 3RD				
BCG				
OTHER			WEAR GLASSES ☐ YES ☐ NO	

SPECIAL TESTS	DATE	RESULT	WHERE GIVEN
PATCH TEST			
PATCH TEST			
PPD			
PPD			
SCHICK			
STS			
OTHER			

OPERATIONS AND HOSPITALIZATION

DATE	PLACE	NATURE OF ILLNESS

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ARMY COMMUNITY SERVICE DAILY WORKSHEET

For use of this form, see AR 608-1; the proponent agency is TAGO.

DATE

PART I - PROGRAM SERVICES

SERVICES PROVIDED	TOTAL POPULATION CHARACTERISTICS																		TOTAL NUMBER SERVED	TIME SPENT
A. RELOCATION SERVICE	E1 - E4		E5 - E6		E7 - E9		W01 - W04		01 - 03		04 - 06		GO		RETIREE		CIV			
	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	RET	FAM MBR	CIV EMP	FAM MBR		
1. IN-PROCESSING																				
2. WELCOME PACKETS																				
3. HOUSEHOLD LENDING CLOSET																				
4. HOUSING ASSISTANCE																				
5. HOSPITALITY/WELCOME VISITS																				
6. NEWCOMER'S BRIEFING																				
7. POST/COMMUNITY TOURS																				
8. OUT-PROCESSING																				
9. RELOCATION FACT SHEETS/ INFORMATION																				
10. PASSPORTS AND OTHER TRAVEL																				
11. ACS RESOURCE LIBRARY																				
12. SPOUSE EMPLOYMENT ASSISTANCE																				
13. FOREIGN-BORN SPOUSES																				
14. WAITING FAMILIES																				
15. SERVICES TO SOLDIERS/FAMILIES IN REMOTE AREAS																				

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PART I - PROGRAM SERVICES *(Cont'd)*

SERVICES PROVIDED	TOTAL POPULATION CHARACTERISTICS																			
	E1 - E4		E5 - E6		E7 - E9		W01 - W04		01 - 03		04 - 06		GO		RETIREE		CIV		TOTAL NUMBER SERVED	TIME SPENT
B. EMERGENCY ASSISTANCE	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MRB	SVC MBR	FAM MBR	SVC MBR	FAM MBR	SVC MBR	FAM MBR	RET	FAM MBR	CIV EMP	FAM MBR		
1. ARMY EMERGENCY RELIEF																				
2. EMERGENCY FOOD																				
3. EMERGENCY SHELTER																				
4. EMERGENCY SHELTER																				
5. FIRE, FLOOD, OR NATURAL DISASTER																				
6. EMERGENCY TRANSPORTATION																				

FAMILY ADVOCACY CASE MANAGEMENT TEAM *(FACMT)* INCIDENT REPORT

For use of this form, see AR 608-1; the proponent agency is TAGO.

REQUIREMENT CONTROL SYMBOL 818(R1)

I. GENERAL INFORMATION

a. SPONSOR SOCIAL SECURITY NUMBER

1 2 3 4 5 6 7 8 9

b. CHILD/SPOUSE ABUSE

IF CASE IS CHILD ABUSE - C
(Complete data in Section I, II, IV, V, VI, VII, VIII, IX, X and XII) 10

IF CASE IS SPOUSE ABUSE - S
(Complete data in Section I, III, IV, V, VI, VIII, IX, X and XII)

c. NAME OF MTF

d. MACOM CODE OF INSTALLATION 11 12

e. MTF CODE 13 14 15 16

f.

CASE NUMBER	
FY	SEQUENCE NUMBER

17 18 19 20 21

REPORT SEQUENCE LETTER 22

g. POINT OF CONTACT AT MTF *(Name)*

h. TELEPHONE NO. OF MTF POC

i. DATE OF INCIDENT

DAY	MO	YEAR

23 24 25 26 27 28

j. DATE OF REPORT

DAY	MO	YEAR

29 30 31 32 33 34

k. TYPE OF REPORT 35

INITIAL	1
FOLLOWUP	2
TRANSFER IN	3
TRANSFER OUT*	4
SUBSEQUENT INCIDENT	5
FINAL *(Close)*	6
REOPEN	7
CORRECTION	0

*TRANSFER WHERE? _____

l. CASE DETERMINATION 36

SUSPECTED	1
ESTABLISHED	2
UNFOUNDED	3

m. TYPE OF MALTREATMENT 37 38

CHILD PHYSICAL ABUSE	01
CHILD SEXUAL ABUSE	02
CHILD NEGLECT	03
CHILD PHYSICAL ABUSE AND NEGLECT	04
CHILD EMOTIONAL MALTREATMENT	05
DEATH	06
SPOUSE ABUSE	07

n. NATURE OF INJURIES 39

MINOR - TREATMENT NOT REQUIRED	1
MODERATE - TREATMENT REQUIRED	2
SERIOUS - HOSPITALIZED	3
PERMANENT DISABILITY	4
FATAL	5

o. CASE BROUGHT TO THE ATTENTION OF THE FACMT BY 40 41

CIVILIAN POLICE	01	SCHOOL - DOD	11
MILITARY POLICE	02	SCHOOL - CIVILIAN	12
CIVILIAN SOCIAL SERVICE AGENCY	03	NEIGHBOR	13
SPONSOR	04	COMPANY COMMANDER	14
SPONSOR'S SPOUSE	05	FAMILY PRACTICE	15
EMERGENCY ROOM	06	WELL BABY CLINIC	16
PEDIATRIC CLINIC	07	COMMUNITY MENTAL HEALTH	17
CHILD CARE CENTER	08	CID	18
SOCIAL WORK SERVICE	09	OTHER MEDICAL CLINIC	19
ANONYMOUS CALLER	10	OTHER _____ *(Specify)*	20

p. LAW ENFORCEMENT INVESTIGATIONS

42

CASE HAS BEEN REFERRED TO THE MILITARY POLICE 1
CASE TO BE REFERRED TO THE MILITARY POLICE 2
CASE WILL NOT BE REFERRED TO THE MILITARY POLICE 3
CASE HAS BEEN REFERRED TO CID 4
OTHER _____ (Specify) 5

II. CHILD IDENTIFICATION DATA

a. FIRST FOUR LETTERS OF CHILD'S FIRST NAME

43 44 45 46

b. SEX OF CHILD

MALE 1
FEMALE 2

47

c. CHILD'S DATE OF BIRTH

DAY MO YEAR

48 49 50 51 52 53

d. RACE OF CHILD

WHITE 1
BLACK 2
OTHER 3

54

e. ETHNIC GROUP OF CHILD *(See Section XI(b))*

55 56

f. ENTER BIRTH ORDER OF CHILD

FIRST CHILD 01 SECOND CHILD 02 THIRD CHILD, ETC. 03, 04, ETC.
FOR PRE-ADOPTIVE CHILDREN ELIGIBLE FOR MEDICAL CARE ENTER 60, 61, 62, ETC.
FOR ALL OTHERS ENTER 00

57 58

g. RELATIONSHIP OF SPONSOR TO CHILD *(See Section XI(c))*

59 60

RELATIONSHIP OF MALTREATOR(S) TO CHILD

61 62 63 64

h. LOCATION OF DOMICILE OF CHILD

ON POST 1 OFF POST 2

65

III. SPOUSE IDENTIFICATION DATA

a. FIRST FOUR LETTERS OF SPOUSE'S FIRST NAME

66 67 68 69

b. SEX OF SPOUSE

MALE 1
FEMALE 2

70

c. SPOUSE'S DATE OF BIRTH

DAY MO YEAR

71 72 73 74 75 76

d. RACE OF SPOUSE

WHITE 1
BLACK 2
OTHER 3

77

e. ETHNIC GROUP OF SPOUSE *(See Section XI(b))*

78 79

f. LOCATION OF SPOUSE

ON POST 1
OFF POST 2

80

g. RELATIONSHIP OF MALTREATOR TO SPOUSE *(See Section XI(c))*

81 82

h. MARRIAGE HISTORY OF SPOUSE

FIRST MARRIAGE 1
SECOND MARRIAGE 2
THIRD MARRIAGE (ETC) 3

83

i. HAS SPOUSE BEEN ABUSED BEFORE THIS INCIDENT

YES 1
NO 2

84

j. IS SPOUSE PREGNANT

YES 1
NO 2

85

k. WAS THE SPOUSE ABUSED BY THE HUSBAND/WIFE BEFORE MARRIAGE

YES 1 NO 2

86

IV. ALCOHOL AND DRUG RELATED

a. DID ACT OF ABUSE OCCUR DURING THE USE OF DRUGS AND/OR ALCOHOL

YES, DRUG 1
YES, ALCOHOL 2
YES, DRUG AND ALCOHOL 3
NO 4

87

b. HAS REFERRAL TO DRUG OR ALCOHOL PROGRAM BEEN MADE

YES 1
NO 2

88

V. SPONSOR IDENTIFICATION DATA

a. SEX OF SPONSOR

MALE 1
FEMALE 2

89

b. AGE OF SPONSOR

YEARS 90 91

c. RACE OF SPONSOR

WHITE 1
BLACK 2
OTHER 3

92

d. ETHNIC GROUP OF SPONSOR *(See Section XI(b))*

93 94

e. MARITAL STATUS OF SPONSOR

MARRIED 1
DIVORCED 2
SEPARATED 3
SINGLE 4

95

f. GRADE CODE OF SPONSOR *(Or Retired Grade)*

E1 E2 E3 E4 E5 E6 E7 E8 E9
W1 W2 W3 W4
01 02 03 04 05 06 GO
CIVILIAN 31

96 97

g. BRANCH OF SERVICE

98

ARMY 1
AIR FORCE 2
NAVY 3
MARINES 4
COAST GUARD 5
OTHER ENTITLED TO SERVICE 6

h. DUTY STATUS OF SPONSOR

99

ACTIVE DUTY MILITARY 1
RETIRED MILITARY 2
DECEASED MILITARY 3
CIVILIAN EMPLOYEE 4
OTHER _____ (Specify) 5

i. LENGTH OF TIME AT CURRENT DUTY STATION

MONTHS 100 101

j. ESTIMATED LENGTH OF TIME LEFT AT CURRENT DUTY STATION

MONTHS 102 103

k. LENGTH OF SERVICE

YEARS 104 105

l. DOES SPONSOR AND SPONSOR'S FAMILY MEMBERS RESIDE TOGETHER

106

YES. 1
NO. SPONSOR ASSIGNED TO LOCATION WHERE FAMILY MEMBERS ARE NOT AUTHORIZED 2
NO. SPONSOR OR FAMILY MEMBERS ELECTED NOT TO JOIN EACH OTHER 3
NO. SPONSOR LEGALLY SEPARATED OR DIVORCED. SUBJECT FAMILY MEMBERS RESIDED WITH SOMEONE ELSE 4

VI. IDENTIFICATION DATA ON MALTREATOR

a. SOCIAL SECURITY NUMBER

107 108 109 110 111 112 113 114 115

b. SEX

MALE 1
FEMALE 2

116

c. AGE

YEARS 117 118

d. RACE

WHITE 1
BLACK 2
OTHER 3

119

e. ETHNIC GROUP *(See Section XI(b))*

120 121

f. MARITAL STATUS

MARRIED 1
SINGLE 2
DIVORCED 3
SEPARATED 4

122

g. DUTY STATUS OF MALTREATOR

123

ACTIVE DUTY MILITARY 1
RETIRED MILITARY 2
CIVILIAN EMPLOYEE 3
OTHER _____ (Specify) 4

h. MILITARY OCCUPATIONAL SPECIALTY CODE *(MOS)*

124 125 126

i. CORRECTIVE ACTIONS FOR MALTREATOR

(1) COMMANDER

REFERRED TO THE FACMT FOR EVALUATION AND TREATMENT	1
ENROLLED IN PROGRAM FOR BATTERERS	2
RESTRICTED TO BARRACKS	3
OFFICIALLY REPRIMANDED	4
CURTAILED FROM ASSIGNMENT	5
BARRED FROM RE-ENLISTMENT	6
DISCIPLINED UNDER UCMJ	7
SEPARATED FROM THE MILITARY	8
OTHER (Specify) _____	9
NONE	0

☐ 127

(2) LOCAL CIVILIAN AUTHORITIES

REFERRED TO MILITARY OR CIVILIAN SOCIAL SERVICE AGENCIES FOR EVALUATION AND TREATMENT	1
ENROLLED IN PROGRAM FOR BATTERERS	2
PENDING LEGAL ACTION	3
OTHER (Specify) _____	4
NONE	5

☐ 128

(3) FACMT

ENROLLED IN PROGRAM FOR BATTERERS	1
PROVIDED EVALUATION AND TREATMENT	2
RECOMMENDED CURTAILMENT OF ASSIGNMENT	3
DEFERRED FROM REASSIGNMENT	4
OTHER (Specify) _____	5
NONE	6

☐ 129

j. GRADE CODE OF MALTREATOR *(Or Retired Grade)*

E1	W1	01	CIVILIAN	31
E2	W2	02		
E3	W3	03		
E4	W4	04		
E5		05		
E6		06		
E7		GO		
E8				
E9				

☐☐ 130 131

k. WAS MALTREATOR ABUSED AS A CHILD

YES 1
NO 2

☐ 132

VII. IDENTIFICATION DATA ON SECOND MALTREATOR

a. SOCIAL SECURITY NUMBER

☐☐☐☐☐☐☐☐☐ 133 134 135 136 137 138 139 140 141

b. SEX

MALE 1
FEMALE 2

☐ 142

c. AGE

YEARS ☐☐ 143 144

d. RACE

WHITE 1
BLACK 2
OTHER 3

☐ 145

e. ETHNIC GROUP *(See Section XI(b))*

☐☐ 146 147

f. MARITAL STATUS

MARRIED 1 DIVORCED 3
SINGLE 2 SEPARATED 4

☐ 148

g. DUTY STATUS OF MALTREATOR

☐ 149

ACTIVE DUTY MILITARY 1 CIVILIAN EMPLOYEE 3
RETIRED MILITARY 2 OTHER (Specify) _____ 4

h. MILITARY OCCUPATIONAL SPECIALTY CODE *(MOS)*

☐☐☐ 150 151 152

i. CORRECTIVE ACTIONS FOR MALTREATOR

(1) COMMANDER

REFERRED TO THE FACMT FOR EVALUATION AND TREATMENT	1
ENROLLED IN PROGRAM FOR BATTERERS	2
RESTRICTED TO BARRACKS	3
OFFICIALLY REPRIMANDED	4
CURTAILED FROM ASSIGNMENT	5
BARRED FROM RE-ENLISTMENT	6
DISCIPLINED UNDER UCMJ	7
SEPARATED FROM THE MILITARY	8
OTHER _____ *(Specify)*	9
NONE	0

153

(2) LOCAL CIVILIAN AUTHORITIES

REFERRED TO MILITARY OR CIVILIAN SOCIAL SERVICE AGENCIES FOR EVALUATION AND TREATMENT	1
ENROLLED IN PROGRAM FOR BATTERERS	2
PENDING LEGAL ACTION	3
OTHER _____ *(Specify)*	4
NONE	5

154

(3) FACMT

ENROLLED IN PROGRAM FOR BATTERERS	1
PROVIDED EVALUATION AND TREATMENT	2
RECOMMENDED CURTAILMENT OF ASSIGNMENT	3
DEFERRED FROM REASSIGNMENT	4
OTHER _____ *(Specify)*	5
NONE	6

155

j. GRADE CODE OF MALTREATOR *(Or Retired Grade)*

E1	W1	01	CIVILIAN	31
E2	W2	02		
E3	W3	03		
E4	W4	04		
E5		05		
E6		06		
E7		GO		
E8				
E9				

156 157

k. WAS MALTREATOR ABUSED AS A CHILD

YES 1
NO 2

158

VIII. MEDICAL CONDITION DIAGNOSED RELATED TO INCIDENT *(In order of severity, USING ICD-9 CODES)*

159 160 161 162 163 | 164 165 166 167 168 | 169 170 171 172 173 | 174 175 176 177 178 | 179 180 181 182 183 | 184 185 186 187 188

IX. STRESS FACTORS PRESENT

FAMILY DISCORD	01	INADEQUATE HOUSING	06	ALCOHOL AND DRUG DEPENDENCY	11
FINANCIAL PROBLEMS	02	SOCIAL ISOLATION	07	CONTINUOUS CHILD CARE	12
RECENT RELOCATION	03	PRESSURE OF HANDICAPPED MEMBER	08	BROKEN FAMILY	13
RECENT SERVICE CONNECTED SEPARATION	04	MENTAL HEALTH PROBLEMS	09	PARENTAL IMMATURITY	14
DISABILITY OF CHILD	05	DISABILITY OF PARENT	10	SPONSOR IN RECEIPT OF RECENT DISCIPINARY ACTION	15
				SEXUAL PROBLEMS	16
				OTHER _____ *(Specify)*	17

189 190 | 191 192 | 193 194 | 195 196 | 197 198

X. SERVICE PROVIDED TO INDIVIDUAL OR FAMILY

a. MILITARY SERVICES PROVIDED

MEDICAL SERVICE	01	EMERGENCY FOOD	14
FOSTER CARE	02	EMERGENCY CLOTHING	15
CHILD CARE	03	CRISIS INTERVENTION	16
HOMEMAKER	04	LEGAL SERVICES	17
MENTAL HEALTH SERVICE/COUNSELING	05	EMERGENCY SHELTER	18
EMPLOYMENT SERVICE	06	PROGRAM FOR BATTERERS	19
HOUSING ASSISTANCE	07	ALCOHOL AND DRUG COUNSELING	20
PARENTS ANONYMOUS	08	COURT ACTION	21
COMMUNITY SELF-HELP GROUP	09	INVESTIGATION	22
PARENTING EDUCATION	10	OTHER _____ *(Specify)*	23
FINANCIAL AID	11	NONE	24
BUDGET COUNSELING	12	ALL OF THE ABOVE	25
EXCEPTIONAL FAMILY MEMBER	13		

199 200 | 201 202 | 203 204 | 205 206 | 207 208

b. CIVILIAN SERVICES PROVIDED

MEDICAL SERVICE	01	EMERGENCY FOOD	14
FOSTER CARE	02	EMERGENCY CLOTHING	15
CHILD CARE	03	CRISIS INTERVENTION	16
HOMEMAKER	04	LEGAL SERVICES	17
MENTAL HEALTH SERVICE/COUNSELING	05	EMERGENCY SHELTER	18
EMPLOYMENT SERVICE	06	PROGRAM FOR BATTERERS	19
HOUSING ASSISTANCE	07	ALCOHOL AND DRUG COUNSELING	20
PARENTS ANONYMOUS	08	COURT ACTION	21
COMMUNITY SELF-HELP GROUP	09	INVESTIGATION	22
PARENTING EDUCATION	10	OTHER _____ *(Specify)*	23
FINANCIAL AID	11		
BUDGET COUNSELING	12	NONE	24
EXCEPTIONAL FAMILY MEMBER	13	ALL OF THE ABOVE	25

209 210 | 211 212 | 213 214 | 215 216 | 217 218

XI. REFERENCE CODES

a. MACOM CODE OF MTF

DARCOM	01	MTMC	06	USARJ	11
FORSCOM	02	TRADOC	07	USMA	12
HSC	03	USACC	08	USAREC	13
INSCOM	04	USAEIGHT	09	WESTCOM	14
MDW	05	USAREUR	10	OTHER _____ *(Specify)*	15

b. ETHNIC GROUP

HISPANIC DESCENT	01	ESKIMO	04
AMERICAN INDIAN	02	MIXED	05
ASIAN DESCENT	03	OTHER THAN ABOVE	06

ARMY COMMUNITY SERVICE INSTALLATION FACT SHEET

For use of this form, see AR 608-1; the proponent agency is TAGO.

DATE

INSTALLATION

STAFF DUTY OFFICER/STAFF DUTY NCO TELEPHONE NO.

STAFF DUTY OFFICER BUILDING NO.

ACS TELEPHONE NO.

1. ARE POST QUARTERS AVAILABLE

☐YES ☐NO

2. HOUSING *(Approximate number by category)*

3. WHICH CATEGORIES OF PERSONNEL ARE AUTHORIZED GOVERNMENT QUARTERS

4. WHAT IS THE WAITING PERIOD FOR GOVERNMENT QUARTERS BY CATEGORY

5. DOES HOUSING HAVE AMPLE SUPPLY OF FURNITURE FOR QUARTERS BY CATEGORY

6. WHAT IS THE HOUSING SITUATION OFF-POST

7. WHAT IS THE APPROXIMATE DISTANCE TO AND SIZE OF THE NEAREST TOWNS/LARGE URBAN AREAS *(100,000 + population)*

8. WHAT IS THE AVAILABILITY OF RENTAL HOUSING BY CATEGORY

9. AVERAGE MONTHLY RENTAL RATES	APT	HOUSE		APT	HOUSE
1 BEDROOM - FURNISHED	$	$	3 BEDROOM - FURNISHED	$	$
1 BEDROOM - UNFURNISHED	$	$	3 BEDROOM - UNFURNISHED	$	$
2 BEDROOM - FURNISHED	$	$	DUPLEX	$	$
2 BEDROOM - UNFURNISHED	$	$	OTHER	$	$

10. AVERAGE MONTHLY UTILITY RATES AND DEPOSITS			
GAS	$	DEPOSIT	$
WATER	$	DEPOSIT	$
ELECTRICITY	$	DEPOSIT	$
TELEPHONE	$	DEPOSIT	$

11. HOUSING OFFICE TELEPHONE NUMBER

12. ARE SCHOOLS FOR EXCEPTIONAL FAMILY MEMBERS AVAILABLE

☐YES ☐NO WHAT AGES WHAT HANDICAPS

WHAT SCHOOL COSTS ARE INVOLVED

OTHER FEES INVOLVED

NAME/ADDRESS OF INSTALLATION RESOURCE PERSON FOR THE EXCEPTIONAL FAMILY MEMBER

GENERAL AREA INFORMATION

13. CLIMATE *(Average temperature)*

SUMMER _____ WINTER _____

14. NEARBY FACILITIES AND PLACES OF INTEREST *(Distance and brief description)*

HUNTING FISHING

SKIING SWIMMING AND BOATING

NATIONAL PARKS AND RESORTS

OTHER

15. EXPENSES AND SAVINGS UNIQUE TO THE AREA

16. COMMENTS

CENTRAL POST INFORMATION

17. MILITARY POPULATION OF THE POST

18. WHAT IS THE PRIMARY MISSION OF THE INSTALLATION

19. WHERE IS POST LOCATED

20. IS A COMMISSARY AVAILABLE ☐YES ☐NO

21. IS A POST EXCHANGE AVAILABLE ☐YES ☐NO

22. ARE GUESTHOUSES AVAILABLE ☐YES ☐NO

22a. RATES

23. IS THERE A MILITARY HOSPITAL AVAILABLE ON THE INSTALLATION ☐YES ☐NO

24. IF NOT, WHAT IS THE DISTANCE TO THE NEAREST MILITARY HOSPITAL

25. WHAT IS THE AVAILABILITY OF CIVILIAN HOSPITALS

26. WHAT IS THE DISTANCE TO THESE CIVILIAN HOSPITALS

27. ARE FAMILY MEMBERS AUTHORIZED DENTAL CARE IN MILITARY FACILITIES ☐YES ☐NO

SCHOOLS

28. ARE ON-POST SCHOOLS AVAILABLE KINDERGARTEN ☐YES ☐NO	DISTANCE	INTERMEDIATE ☐YES ☐NO	DISTANCE
ELEMENTARY ☐YES ☐NO		HIGH SCHOOL ☐YES ☐NO	
29. ARE CIVILIAN SCHOOLS AVAILABLE KINDERGARTEN ☐YES ☐NO		INTERMEDIATE ☐YES ☐NO	
ELEMENTARY ☐YES ☐NO		HIGH SCHOOL ☐YES ☐NO	

30. IS A COLLEGE OR UNIVERSITY AVAILABLE NEARBY ☐YES ☐NO DISTANCE

CHILD CARE

31. IS CHILD CARE AVAILABLE ON-POST ☐YES ☐NO

32. IF SO, WHAT KIND

CHILD SUPPORT SERVICES

☐DAY CARE
☐PRE SCHOOL
☐FAMILY DAY CARE

33. IS THERE AN ON-POST TRAILER PARK ☐YES ☐NO

IS THERE AN OFF-POST TRAILER PARK ☐YES ☐NO

34. INDICATE WHICH OF THE FOLLOWING FACILITIES/ACTIVITIES ARE AVAILABLE

OFFICERS' CLUB	☐YES	☐NO	CRAFTSHOPS	☐YES	☐NO
NONCOMMISSIONED OFFICERS CLUB	☐YES	☐NO	AUTOMOTIVE	☐YES	☐NO
CONSOLIDATED CLUB	☐YES	☐NO	PHOTO	☐YES	☐NO
ENLISTED CLUB	☐YES	☐NO	CERAMICS	☐YES	☐NO
TEEN CLUB	☐YES	☐NO	LEATHER	☐YES	☐NO
MAJOR SPORTS	☐YES	☐NO	LIBRARY	☐YES	☐NO
GOLF COURSE	☐YES	☐NO	RECREATION CENTER	☐YES	☐NO
GYMNASIUM	☐YES	☐NO			
ROD AND GUN CLUB	☐YES	☐NO	RECREATION LODGING	☐YES	☐NO
RIDING CLUB	☐YES	☐NO			
SWIMMING POOL	☐YES	☐NO	OTHER _____ *(Specify)*		
THEATERS	☐YES	☐NO			

35. IS THERE A FAMILY MEMBER EMPLOYMENT ASSISTANCE PROGRAM ON YOUR INSTALLATION

☐YES ☐NO POC NAME _____ AUTOVON _____ COMMERCIAL _____

36. LIST AVAILABLE ON-POST INDIVIDUAL AND FAMILY ENRICHMENT PROGRAMS AND SPONSORING AGENCY

COMMENTS

AGENCY FOLLOW-UP

For use of this form, see AR 608-1; the proponent agency is TAGO.

DATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3012.
PRINCIPAL PURPOSE: To obtain client's assessment of ACS Information and Referral services.
ROUTINE USES: To evaluate effectiveness of ACS Information and Referral System.
DISCLOSURE: Providing information is voluntary. Not providing information would limit further evaluation to ensure appropriate services were provided.

NAME

TELEPHONE

ADDRESS *(Include ZIP Code)*

CASE NUMBER

TYPE OF INFORMATION AND REFERRAL SERVICE PROVIDED TO CLIENT *(Check one)*

- ☐ INFORMATION ONLY
- ☐ REFERRAL
- ☐ ADVOCACY/RE-REFERRAL
- ☐ NO KNOWN INFORMATION OR RESOURCE COULD BE IDENTIFIED

TYPE OF FOLLOW-UP *(Check one)*

- ☐ MAIL
- ☐ TELEPHONE
- ☐ PERSONAL INTERVIEW

INFORMATION PROVIDED TO CLIENT *(For Information Cases Only)*

WAS INFORMATION ACTED UPON *(If no, indicate why)*

☐ YES ☐ NO

WAS INFORMATION CORRECT *(If no, indicate why)*

☐ YES ☐ NO

REFERRAL PROVIDED TO CLIENT *(For Referral Cases Only)*

PROBLEM	SERVICE PROVIDED	AGENCY	AGENCY CONTACTED		REASONS *(If no)*	SERVICE SATISFACTORY		ADVOCACY OR RE-REFERRAL ACTION TAKEN	
			YES	NO		YES	NO	YES	NO

WOULD CLIENT RE-UTILIZE INFORMATION AND REFERRAL SERVICE *(Check one)*

☐ YES ☐ NO

DA FORM 5185-R, Apr 83

CLIENT INQUIRY AND DISPOSITION DATA

For use of this form, see AR 608-1; the proponent agency is TAGO.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3012.

PRINCIPAL PURPOSE: To provide essential background information to assess socioeconomic status of the person seeking assistance, and to coordinate and facilitate family assistance services.

ROUTINE USES: (1) To identify specific problems that service/family member is experiencing, (2) As a source of data for developing ACS services as needed by military personnel and their family members, (3) To provide a record for following assistance to the service family member experiencing the problem.

DISCLOSURE: Providing information is voluntary. Not providing information would impede and limit services provided by ACS to individuals seeking assistance.

NAME	DATE OF INQUIRY
	TELEPHONE
ADDRESS *(Include ZIP Code)*	CASE NUMBER
	DATE ACTION COMPLETED

PART I - CLIENT CHARACTERISTICS

AGE	SEX	RANK	YEARS OF SERVICE

LIVING ARRANGEMENT *(Living alone, with spouse, with family, with unrelated individuals)*	HOUSING STATUS *(Living in single family dwelling, apartment, etc.)*	EDUCATION *(Number of years of schooling)*	TRANSPORTATION REQUIRED *(Check one)*
			☐ YES ☐ NO

PART II - PERFORMANCE INFORMATION

SOURCE OF INQUIRY *(For whom inquiry is being made, e.g. self, relative, etc.)*	METHOD OF INQUIRY *(Telephone, walk-in, mail, answering service)*	KNOWLEDGE OF SERVICE *(Through out-reach, T.V., radio, posters, other agencies, etc.)*	TIME OF INQUIRY *(Day of the week, a.m. or p.m., after-hours)*

DISPOSITION OF INQUIRY *(Type of services provided, e.g., information only, referral, etc.)*	NUMBER OF CONTACTS *(Number of contacts required to complete action.)*	FOLLOW-UP SCHEDULE *(If follow-up is to be done, give date)*	TYPE OF FOLLOW-UP *(When individual consents to follow-up, list type of follow-up, e.g., mail, telephone, etc.)*

PART III - PROBLEM/SERVICE INFORMATION

PROBLEMS	SERVICE SUGGESTED OR REFERRED

DA FORM 5186-R, Apr 83

Glossary

Section I
Abbreviations

ACS ..... Army community service
ADAPCP ..... alcohol and drug abuse prevention and control program
ADCO ..... alcohol and drug control officer
ADP ..... automatic data processing
AER ..... Army Emergency Relief
AFAP ..... Army family advocacy program
AFP ..... appropriated funds
AFRTS ..... Armed Forces Radio and Television Service
ARC ..... American Red Cross
ARNG ..... Army National Guard
CAP ..... commercial activities program
CDS ..... child development services
CID ..... Criminal Investigation Command
CMHA ..... community mental health activity
COE ..... Chief of Engineers
COHORT ..... *cohesive operational readiness training*
CONUS ..... continental United States
CPO ..... civilian personnel office
CSS ..... child support services
CTA ..... common table of allowances
DA ..... Department of the Army
DIC ..... deputy installation commander
DOD ..... Department of Defense
DODDS ..... Department of Defense Dependent Schools
DPCA ..... Director of Personnel and Community Activities
FACMT ..... family advocacy case management team
FAPC ..... family advocacy program coordinator
HQDA ..... Headquarters, Department of the Army
HR ..... human resources
MACOM ..... major Army command
MEDCEN ..... medical center
MEDDAC ..... medical department
MIA ..... missing in action
MILPERCEN US Army Military Personnel Center
MTF ..... medical treatment facility
MWR ..... morale, welfare and recreation
NAF ..... nonappropriated funds
NAFI ..... nonappropriated funds instrumentality
NCOIC ..... noncommissioned officer in charge
OPM ..... Office of Personnel Management
PAD ..... patient administration division
PAO ..... public affairs officer
PARR ..... Program Analysis Resource Review
PCS ..... permanent change in station
POC ..... point of contact
POW ..... prisoner of War
PX ..... post exchange
RCS ..... requirement control symbol
ROTC ..... Reserve Officer Training Corps
SJA ..... Staff Judge Advocate
SOP ..... standing operating procedure
TAG ..... The Adjutant General
TJAG ..... The Judge Advocate General
TSG ..... The Surgeon General
UCMJ ..... Uniform Code of Military Justice
USAF ..... US Air Force
USAR ..... US Army Reserve
USAREC ..... US Army Recruiting Command
USCG ..... US Coast Guard
USN ..... US Navy
USMC ..... US Marine Corps

Section II
Terms

Abuse
Direct physical injury, trauma, or emotional harm intentionally inflicted on a child or spouse.

Army commercial activity
An activity, including personnel, facilities, and equipment, operated and managed by the Army, which provides a product or service that could be obtained from a private source.

Army Community Service Program
A program designed to assist the commander by identifying emerging social problems; to assist service members and their families through the development and provision of programs and services designed to meet individual and community needs.

Army Family Advocacy Program
A program designed to address prevention, identification, evaluation, treatment, followup, and reporting of child or spouse maltreatment. This includes physical abuse, psychological and emotional abuse, sexual abuse, physical neglect of children, and psychological and emotional neglect of children.

At risk
A situation involving a family or family member who is vulnerable to child abuse or neglect or spouse abuse.

Central Registry
An Army-wide index of abuse reports.

Child
An unmarried person, whether natural child, adopted

Installation population
The population on which manpower staffing is based as defined in DA Pam 570–551.

Lending closet
The temporary loan of household items to assist service members and their families.

Maltreatment
A general assessment term referring to abuse or neglect.

Military/installation and community population
The actual population eligible for services provided through the installation ACS program.

Outreach
A method of providing social services by reaching out to potential consumers rather than waiting for them to request assistance.

Spouse
A partner in a lawful marriage.

Spouse abuse
Direct, nonaccidental physical injury inflicted on a partner in a lawful marriage.

Statement of work
A document that describes accurately the essential program and technical requirements for items, materials, or services including the standards used to determine whether the requirements have been met.

Victim
An individual who has been abused or neglected.

Volunteer coordinating committee
Consists of an ACS officer, volunteer supervisor, assistant volunteer supervisor, committee chairperson, honorary advisors, or their appointed representatives.

Volunteer service guidelines
Descriptions of support and service activities performed by volunteers.

By Order of the Secretary of the Army:

E. C. MEYER
General, United States Army
Chief of Staff

Official:

ROBERT M. JOYCE
Major General, United States Army
The Adjutant General

Distribution: To be distributed in accordance with DA Form 12–9A requirements for AR, Personnel Affairs:Active Army, ARNG, USAR, D.

VOLUNTEER AGREEMENT

For use of this form, see AR 608-1; the proponent agency is TAGO.

I, the undersigned, desire to volunteer my services to the _____

Program at _____.

(Installation/Community)

I expressly agree that my services are being performed as a volunteer and that I am not, solely because of these services, an employee of the United States Government or any instrumentality thereof. I expressly agree that I expect no present or future salary, wages, or related benefits as payment for these volunteer services.

_____ _____

(Typed/Printed Name and Signature) *(Date)*

Accepted.

_____ _____

(Typed/Printed Name and Signature) *(Date)*

DA FORM 4712-R, 1 Jul 78

ARMY COMMUNITY SERVICE
VOLUNTEER DAILY TIME RECORD

For use of this form, see AR 608-1; the proponent agency is TAGO.

NAME

COMMITTEE ASSIGNMENT	DATE	POSITION

INSTRUCTIONS

Upon resignation, retirement, or transfer, a duplicate of this record will be furnished for the personal file of the volunteer. In case of transfer, original record will be furnished the gaining organization. Upon completion of the calendar year, the annual total will be recorded on DA Form 4162-R.

19	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
JAN																																
FEB																																
MAR																																
APR																																
MAY																																
JUN																																
JUL																																
AUG																																
SEP																																
OCT																																
NOV																																
DEC																																

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
TRAVEL TIME													
PRODUCTIVE TIME													
TOTAL TIME													

DA FORM 4713-R, Apr 83 EDITION OF JUL 78 IS OBSOLETE.

19	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
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FEB																																
MAR																																
APR																																
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DEC																																

	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEP		OCT		NOV		DEC		TOTAL
TRAVEL TIME																									
PRODUCTIVE TIME																									
TOTAL TIME																									

REMARKS

ARMY COMMUNITY SERVICE
VOLUNTEER SERVICE RECORD

For use of this form, see AR 608-1; the proponent agency is TAGO.

INSTRUCTIONS

Upon resignation, retirement, or transfer, a duplicate of this record will be furnished for the personal file of the volunteer. In case of transfer, original record will be furnished the gaining organization.

SEE REVERSE FOR PRIVACY ACT STATEMENT BEFORE COMPLETING THIS FORM

NAME *(Last, First, MI)*

ADDRESS *(Include ZIP Code)*

PHONE NO. DRIVE A CAR ☐ YES ☐ NO

SEX ☐ MALE ☐ FEMALE AGE

CHILDREN AT HOME ☐ NONE ☐ PRESCHOOL ☐ IN SCHOOL

SPONSOR'S NAME ☐ OFFICER ☐ ENLISTED

☐ ACTIVE DUTY ☐ RETIRED ☐ DECEASED

SPONSOR'S UNIT OF ASSIGNMENT

EDUCATION 1 2 3 4 5 6 7 8 9 10 11 12

COLLEGE + DEGREES

1 2 3 4

SPECIAL COURSES

LANGUAGES

INITIAL COMMITMENT

☐ 3 MONTHS ☐ 6 MONTHS ☐ OTHER_____

WORK EXPERIENCE

VOLUNTEER EXPERIENCE

INTERESTS, SKILLS, HOBBIES

DATE

SIGNATURE

DA FORM 4162-R, Apr 83 EDITION OF JUL 78 IS OBSOLETE.

AWARDS AND SPECIAL RECOGNITION			TRAINING		
DATE	TYPE	PRESENTED AT	DATE	TYPE	HOURS COMPLETED

VOLUNTEER ANNUAL HOUR RECORD

19	19	19	19	19	19	19	19	19	19	19	19	19	19

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY:	Title 10, United States Code, Section 3012.
PRINCIPAL PURPOSE(S):	To maintain records of hours volunteered and awards received. To record essential background information on volunteers.
ROUTINE USES:	Developing and coordinating volunteer services in the Army Community Service Program. Recruiting volunteers. Determining qualifications and task assignments for volunteers. Planning volunteer awards programs.
DISCLOSURE:	Providing information is voluntary. Not providing information will prevent keeping a record of individual volunteer qualifications and services; may prevent volunteers from receiving awards.

CONSUMER COMPLAINT

For use of this form, see AR 608-1; the proponent agency is TAGO.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY:	Title 5, United States Code, Section 301
PRINCIPAL PURPOSE:	To provide information needed to assist military consumers in resolving their complaints.
ROUTINE USES:	To identify specific problems that service/family members are experiencing, and as a source of data for developing ACS services as needed by military consumers.
DISCLOSURE:	Providing information is voluntary. Not providing information would impede and limit services provided by ACS to individuals seeking assistance.

NAME

DATE/TIME

UNIT/ORGANIZATION

HOME PHONE

BUSINESS PHONE

ADDRESS *(No., Street, City, State and ZIP Code)*

STATUS

☐ ACTIVE DUTY ☐ RETIRED ☐ SPOUSE/FAMILY MEMBER ☐ OTHER _____

NAME AND ADDRESS OF AGENCY/SERVICE INVOLVED *(Include No., Street, City, State and ZIP Code)*

DATE OF TRANSACTION

NAME OF SALES PERSON

PRODUCT OR SERVICE DESCRIPTION

DID YOU SIGN A CONTRACT OF LEASE *(If yes, attach a copy, if possible)*

☐ YES ☐ NO

ACCOUNT NUMBER *(If any)*

WAS THE ITEM/SERVICES YOU PURCHASED ADVERTISED *(If yes, give when, how, where and what did the advertisement say) (Attach a copy, if possible)*

☐ YES ☐ NO

DID THE SALES PERSON MAKE ANY REPRESENTATIONS TO YOU REGARDING THE PRODUCT OR SERVICE PURCHASED WHICH YOU FEEL TO BE DECEPTIVE OR MISLEADING *(If yes, please describe)*

☐ YES ☐ NO

HAVE YOU COMPLAINED TO THE COMPANY *(If yes, to whom)*

☐ YES ☐ NO

WHAT WAS THEIR RESPONSE

WAS THIS YOUR FIRST COMPLAINT WITH THE COMPANY

☐ YES ☐ NO

IS THERE A BANK OR FINANCE COMPANY INVOLVED *(If yes, give name of company, and address) (Include No., Street, City, State and ZIP Code)*

☐ YES ☐ NO

HAVE YOU HAD ANY CONTACT OR CORRESPONDENCE WITH THE BANK, FINANCE COMPANY, ETC. *(If yes, please state the nature of the contact)*

☐ YES ☐ NO

PLEASE DESCRIBE HOW YOU FEEL THE PROBLEM SHOULD BE RESOLVED

FOR OFFICE USE ONLY

WHERE WAS THE CONSUMER REFERRED OR WHAT IS BEING DONE TO RESPOND TO THE COMPLAINT

DESCRIBE FINAL RESOLUTION OF THE CASE

OTHER COMMENTS

DATE	TYPED NAME AND SIGNATURE OF INTERVIEWER